

NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by first submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for making, amending, or repealing any rule. (A.R.S. §§ 41-1013 and 41-1022)

NOTICE OF PROPOSED RULEMAKING

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 38. BOARD OF HOMEOPATHIC AND INTEGRATED MEDICINE EXAMINERS

Editor's Note: The following Notice of Proposed Rulemaking was reviewed per Laws 2009, 3rd Special Session, Ch. 7, § 28. (See the text of § 28 at 15 A.A.R. 1942, November 20, 2009.) The Governor's Office authorized the notice to proceed through the rulemaking process on May 4, 2010.

[R11-24]

PREAMBLE

1. Sections Affected

R4-38-103
R4-38-103
R4-38-104
R4-38-104
R4-38-105
R4-38-105
R4-38-106
R4-38-107
R4-38-107
R4-38-107
R4-38-108
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R4-38-109
R4-38-109
R4-38-110
R4-38-110
R4-38-111
R4-38-112
R4-38-112
R4-38-113
R4-38-115
R4-38-116
R4-38-117
R4-38-118

Rulemaking Action

Renumber
New Section
Renumber
Amend
Renumber
Amend
Renumber
Repeal
Renumber
Amend
Renumber
Amend
Renumber
New Section
Renumber
Amend
Renumber
Repeal
Renumber
Amend
Amend
New Section
New Section
New Section

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 32-2904(B)(1)

Implementing statute: A.R.S. §§ 32-2912(F)(3), 32-2913(A), 32-2915(F) and (G)

3. List of all previous notices appearing in the *Register* addressing the proposed rules:

Notice of Rulemaking Docket Opening: 17 A.A.R. 512, April 8, 2011 (*in this issue*)

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Chris Springer, Executive Director

Address: Board of Homeopathic and Integrated Medicine Examiners
1400 W. Washington St., Suite 230

Notices of Proposed Rulemaking

Phoenix, AZ 85007

Telephone: (602) 542-3095

Fax: (602) 542-3093

E-mail: chris.springer@azhomeopathbd.az.gov

5. An explanation of the rules, including the agency's reasons for initiating the rulemaking:

The Board is amending R4-38-106 to delete the oral examination requirement. R4-38-107 is being repealed to conform to the 2008 amendment of A.R.S. § 32-2913, which requires all applicants to pass an examination prescribed by the Board. Before the statute was amended in 2008, an applicant could request a waiver of the examination. However, to ensure that licensees are competent, the legislature decided to require all of them to pass an examination. In 2008, the legislature also amended A.R.S. § 32-2915 to require that license renewal be done on a licensee's anniversary date rather than have all licensees renew at the end of each calendar year. The rules are being amended to provide necessary information regarding license application and renewal. The legislature also added a provision to A.R.S. § 32-2915 requiring a licensee to obtain 20 hours of Board-approved continuing education annually. Sections are being added to provide guidance regarding the requirement.

6. A reference to any study relevant to the rules that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

None

7. A showing of good cause why the rules are necessary to promote a statewide interest if the rules will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

The Board will incur the costs associated with the rulemaking, informing applicants and licensees of the new requirements, and enforcing the rules. Much of this cost results from legislative action rather than the rulemaking.

Most of the economic impact on applicants and licensees results from legislative action rather than this rulemaking. The costs associated with obtaining 20 hours of Board-approved continuing education will be minimal because most licensees already participate in continuing education. There may be economic cost associated with passing an examination, especially if an applicant does not pass. However, this is a necessary requirement to enable the Board to fulfill its obligation to protect public health and safety. There are administrative costs associated with applying for and renewing licensure. However, the benefits of being licensed outweigh the costs of making application.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Chris Springer, Executive Director

Address: Board of Homeopathic and Integrated Medicine Examiners
1400 W. Washington St., Suite 230
Phoenix, AZ 85007

Telephone: (602) 542-3095

Fax: (602) 542-3093

E-mail: chris.springer@azhomeopathbd.az.gov

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rules or, if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rules:

An oral proceeding regarding the proposed rules will be held as follows:

Date: May 10, 2011

Time: 11:30 a.m.

Location: 1400 W. Washington St., B-1
Phoenix, AZ 85007

The rulemaking record will close at 5:00 p.m. on May 12, 2011

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

None

12. Incorporations by reference and their location in the rules:

None

13. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 38. BOARD OF HOMEOPATHIC AND INTEGRATED MEDICINE EXAMINERS

ARTICLE 1. GENERAL

Section

~~R4-38-103.~~ Postgraduate Requirements for Licensure

~~R4-38-103.~~ ~~R4-38-104.~~ Approval of Approved Postgraduate Coursework

~~R4-38-104.~~ ~~R4-38-105.~~ Approval of Preceptorship

~~R4-38-105.~~ ~~R4-38-106.~~ Fees

~~R4-38-107.~~ Waiver of Written Examination

~~R4-38-106.~~ ~~R4-38-107.~~ Examinations Examination

~~R4-38-108.~~ Application for Licensure

~~R4-38-109.~~ License Renewal

~~R4-38-110.~~ Repealed

~~R4-38-108.~~ ~~R4-38-110.~~ Notification of Address Changes Change in Contact Information

~~R4-38-109.~~ ~~R4-38-111.~~ Experimental Forms of Diagnosis and Treatment

~~R4-38-112.~~ Registering Use of Experimental Forms of Diagnosis and Treatment

~~R4-38-111.~~ ~~R4-38-112.~~ Peer Review

~~R4-38-113.~~ Chelation Therapy Practice Requirements

~~R4-38-115.~~ Use of Title and Abbreviation

~~R4-38-116.~~ Continuing Education Requirement

~~R4-38-117.~~ Application for Approval of a Continuing Education

~~R4-38-118.~~ Audit of Compliance and Sanction for Noncompliance with Continuing Education Requirement

ARTICLE 1. GENERAL

R4-38-103. Postgraduate Requirements for Licensure

Under A.R.S. § 32-2912(F)(3), an applicant for licensure shall:

1. Have a degree of doctor of medicine in homeopathy issued by a homeopathic college or other Board-approved educational institution, or
2. Have successfully completed:
 - a. Formal postgraduate courses approved under R4-38-104, or
 - b. A preceptorship approved under R4-38-105.

~~R4-38-103.~~ R4-38-104. Approval of Approved Postgraduate Coursework

A. An applicant for licensure who does not have a degree of doctor of medicine in homeopathy shall identify on a form supplied by the Board who seeks licensure based on successful completion of formal postgraduate courses shall: of

1. Complete at least 300 hours of formal postgraduate education courses in one or more of the treatment modalities specified in subsections (C)(1) through (6).
2. Ensure that with at least 40 hours of the 300-hour requirement 300 required hours are in a course of classical homeopathy. To receive credit for formal postgraduate coursework, the applicant shall, and
3. submit the following Submit with the application required under R4-38-108 a statement from the sponsor of the formal postgraduate course that includes:
 - a. The applicant's name.
 - b. The name of the course sponsor.
 - c. The dates on which the course was taken.
 - d. A brief description of the course content.
 - e. The number of hours completed, and
 - f. Whether the applicant was successful in the course.

1. A statement showing completion of the coursework and a brief description of the content; and
2. A certificate of attendance showing evidence of the number of hours successfully completed.

B. The Board shall approve a formal postgraduate course if the Board determines that:

1. the The course content provides training in one or more of the treatment modalities specified in subsections (C)(1) through (6).
2. the educational qualifications of the instructors There is evidence that the course instructor is qualified in demonstrate

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- ~~sufficient knowledge of the subject matter of the course, and~~
3. ~~the~~ The course sponsor is recognized within the homeopathic, osteopathic, or allopathic medical profession as a provider of postgraduate training and continuing education; ~~or The Board shall approve a course of classical homeopathy, if the course includes case-taking, repertory use, materia medica, philosophy and history of homeopathy, acute remedies, constitutional prescribing, posology, homeopathy prescription policy, and remedy handling policy.~~
 4. An applicant who has completed postgraduate coursework in treatment modalities not specified in subsections (C)(1) through (6) shall submit evidence of the postgraduate coursework with the application sufficient to enable the Board to determine whether the postgraduate coursework is related to the practice of homeopathic medicine as defined in statute.

C. No change

1. No change
 - a. No change
 - i. No change
 - ii. No change
 - b. No change
2. No change
3. No change
4. No change
5. No change
 - a. No change
 - b. No change
6. No change

~~R4-38-104. R4-38-105. Approval of Preceptorship~~

A. Instead of evidence of formal postgraduate courses, an An applicant may qualify for who seeks licensure based on successful completion of a preceptorship shall obtain the Board's approval of the preceptorship conducted by a preceptor qualified to provide instruction in one or more of the treatment modalities listed in A.R.S. § 32-2901(22) by submitting the following with the application the following required under R4-38-108:

1. A notarized affidavit from each preceptor on the preceptor's letterhead attesting to:
 - a. The educational qualifications of the preceptor ~~to include the number of years the preceptor has been conducting preceptorships;~~
 - b. The number of years the preceptor has been conducting preceptorships.
 - ~~b.c.~~ The dates of the preceptorship;
 - ~~e.d.~~ An outline of the training conducted;
 - e. ~~and each~~ Which of the treatment modality modalities listed in A.R.S. § 32-2901(22) were involved in the training;
 - ~~d.f.~~ The number of hours of didactic and clinical training in each treatment modality; and
 - ~~e.g.~~ The general nature of the services performed during the training; and
2. A summary from the applicant of each preceptorship including:
 - a. The name of each preceptor;
 - b. The treatment modalities included in each preceptorship; and
 - c. The total number of hours claimed instead of formal postgraduate courses.

B. The Board shall approve a preceptorship under this Section if the Board determines that:

1. The preceptorship provides training in one or more of the treatment modalities specified in R4-38-104;
2. The preceptorship involves a balance of didactic and clinical training;
3. The preceptor has been in full-time clinical practice for a least three years and meets the educational requirements of R4-38-302(C) in the treatment modality being precepted; and
4. If the preceptorship involves training in classical homeopathy, the preceptorship includes case-taking, repertory use, materia medica, philosophy and history of homeopathy, acute remedies, constitutional prescribing, posology, homeopathy prescription policy, and remedy handling policy.

~~R4-38-105. R4-38-106. Fees~~

A. No change

1. No change
2. No change
3. No change
4. No change
5. No change
6. No change

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7. No change
8. No change
9. No change
10. No change
11. No change
12. No change

B. No change

1. No change
2. No change
3. No change
4. No change
5. No change
6. No change
7. No change
8. No change

R4-38-107. Waiver of Written Examination

A. The following applies to an applicant requesting waiver under A.R.S. § 32-2913(A):

1. ~~The Board shall not issue a license based on a waiver of the written examination without completion of an oral examination and a personal interview.~~
2. ~~At the Board's discretion, an oral examination and personal interview may be conducted by a telephone conference call with a majority of the Board present.~~

B. ~~Based on the application, oral examination, and personal interview, the Board shall determine whether the applicant qualifies for a waiver.~~

R4-38-106. R4-38-107. Examinations Examination

A. The examination for a license consists of ~~three~~ two parts:

1. ~~A timed written examination with a passing grade of 70% that includes questions the Board deems appropriate for the category of addressing the treatment modality for which the applicant provides evidence under R4-38-103 that are similar to those expected to be included in an examination in an approved postgraduate course in the treatment modality under R4-38-103 modalities listed in A.R.S. § 32-2901(22). To pass the written examination, an applicant shall obtain a score of at least 70 percent;~~
2. ~~An oral examination on one or more of the treatment modalities in R4-38-103 based on an actual clinical case history. The applicant shall present to the Board a summary of the clinical management of the sample case; and~~
3. ~~A personal interview with the Board to examine the an applicant's personal and professional history as it applies to homeopathic medicine. The Board may ask questions to clarify issues regarding the applicant's competence to engage in the practice of medicine safely, unprofessional conduct in the applicant's professional record, and whether the scope of the applicant's practice falls within the definition scope of homeopathic medicine as defined at A.R.S. § 32-2901(22).~~

B. ~~An applicant who applies for licensure and provides evidence of postgraduate education under R4-38-103(C) may use a copy of Kent's Repertory or other repertory with clinically updated rubrics as a reference during the written examination. An applicant shall not use a computer or other written material during the written examination.~~

R4-38-108. Application for Licensure

A. To apply for licensure, an applicant shall submit the following directly to the Board:

1. An application form that contains the following information about the applicant:
 - a. Name as the applicant wants the name to appear on a license;
 - b. Social Security number, as required under A.R.S. §§ 25-320(P) and 25-502(K);
 - c. Date and place of birth;
 - d. Personal identifying characteristics including gender, weight, height, eye and hair colors, and any identifying marks;
 - e. Business name and address;
 - f. Residential address;
 - g. Business telephone and fax numbers;
 - h. E-mail address;
 - i. Date on which the applicant expects to take the written examination required under A.R.S. § 32-2913;
 - j. Name of the approved medical school from which the applicant obtained an allopathic or osteopathic medical degree and the date of the degree;
 - k. Name of the hospital program at which the applicant served as an intern and the years of the internship;
 - l. Names and addresses of three physicians who will send the Board letters of recommendation for the applicant;

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- m. List of the states or other jurisdictions in which the applicant is or ever has been licensed to practice medicine;
- n. List of specialty colleges of which the applicant is a member;
- o. List of specialty boards by which the applicant is certified;
- p. List of the places and dates that the applicant has practiced medicine;
- q. Statement indicating whether the applicant:
 - i. Has, within the last 10 years, had a medical malpractice claim filed against the applicant including any claim for which no corresponding lawsuit was filed;
 - ii. Has ever been convicted of or pled guilty or nolo contendere to a criminal charge requiring adjudication in an adult court of record;
 - iii. Has been charged with a crime that is pending adjudication in an adult court of record;
 - iv. Has had a state or other jurisdiction refuse or deny the applicant a license to practice medicine or has allowed the applicant to withdraw a license application instead of being refused or denied a license to practice medicine;
 - v. Has had a state or other jurisdiction take disciplinary action towards the applicant's license to practice medicine including placing the license on probation, suspending the license, limiting or restricting the license, revoking the license, or accepting surrender of the license while other disciplinary measures are considered;
 - vi. Has had a state or other jurisdiction, including a federal agency, suspend, limit, restrict, revoke, deny, or accept surrender of the applicant's privilege to possess, dispense, or prescribe controlled substances;
 - vii. Has, within the last 10 years, had a mental illness or psychological condition that impaired the applicant's ability to practice medicine or function as a medical student;
 - viii. Is now or has been within the last 10 years dependent upon alcohol or drugs; and
 - ix. Has had a specialty board or college suspend, revoke, or deny certification to the applicant.
- r. Notarized signature and attestation that the information provided is true, correct, and complete;
- 2. A summary and evidence of completing the 300 hours of postgraduate coursework required under R4-38-104 or the preceptorship required under R4-38-105;
- 3. If the answer to any item in subsections (A)(1)(q)(i) through (ix) is yes, detailed information regarding the nature, date, and location of the incident, identity of the agency, court, or organization involved, action taken, and current status;
- 4. An Arizona Statement of Citizenship and documentary evidence of U.S. citizenship or qualified alien status;
- 5. A list of the homeopathic modalities the applicant intends to make available under the applicant's supervision if the applicant is licensed;
- 6. If the applicant intends to use an experimental form of diagnosis or treatment in the applicant's homeopathic medical practice, a copy of the written informed consent materials that a patient will sign before examination or treatment;
- 7. Two photographs of the applicant's face taken within the last 60 days;
- 8. A copy of the membership card provided by a specialty college of which the applicant is a member;
- 9. A copy of the certification card provided by a specialty board by which the applicant is certified;
- 10. A completed and signed form authorizing entities to release to the Board information regarding the applicant;
- 11. A current curriculum vitae that includes all professional activity from medical school to the present; and
- 12. The license application fee specified in R4-38-106.
- B.** An applicant for licensure shall ensure that the following information is submitted directly to the Board:
 - 1. Verification of graduation provided by the allopathic or osteopathic medical college from which the applicant graduated;
 - 2. Letters of recommendation, on professional letterhead and notarized, from three licensed physicians; and
 - 3. Verification of licensure from every jurisdiction in which the applicant is or ever has been licensed to practice medicine.

R4-38-109. License Renewal

- A.** The Board shall provide a licensee with at least 30-days' notice of the need to renew the licensee's license. It is the responsibility of the licensee to renew timely. Failure to receive notice of the need to renew does not excuse failure to renew timely.
- B.** Under A.R.S. § 32-2915(G), a licensee who wishes to continue practicing homeopathic medicine shall submit the license renewal materials described in subsection (E) annually on or before the last day of the month in which the license was initially issued.
- C.** A licensee who fails to comply with subsection (E) by the date specified in subsection (B) may apply for license renewal within 60 days after the date specified in subsection (B) by:
 - 1. Submitting to the Board the license renewal materials described in subsection (E), and
 - 2. Paying the late renewal penalty prescribed in R4-38-106.
- D.** If a licensee fails to comply with either subsection (B) or (C), the licensee's license expires and the licensee shall immediately cease practicing homeopathic medicine. A licensee whose license expires may obtain licensure only by complying

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again with R4-38-108 and taking the examination specified in R4-38-107.

- E.** To renew a license issued by the Board, a licensee shall submit the following directly to the Board:
1. A license renewal application that contains the following information about the applicant:
 - a. Name.
 - b. License number.
 - c. Business name and address.
 - d. Residential address.
 - e. Business telephone number.
 - f. E-mail address.
 - g. Address and telephone numbers of each location at which the licensee practices.
 - h. Number of the active M.D. or D.O. license held by the licensee and name of the state that issued the license; and
 - i. A statement indicating whether during the last 12 months:
 - i. A licensing authority of another jurisdiction denied the licensee a license to practice allopathic or osteopathic medicine and if so, the name of the jurisdiction, date of the denial, and an explanation of the circumstances;
 - ii. A licensing authority of another jurisdiction revoked, suspended, limited, restricted, or took other action regarding a license of the licensee and if so, the name of the jurisdiction taking action, nature and date of the action taken, and an explanation of the circumstances;
 - iii. The licensee has been convicted of a crime other than a minor traffic offense, including driving under the influence of drugs or alcohol, and if so, the name of the jurisdiction in which convicted, nature of the crime, date of conviction, and current status;
 - iv. A claim was made or a lawsuit was filed against the licensee alleging professional malpractice or negligence in the practice of homeopathic, allopathic, or osteopathic medicine and if so, the claim or case number, date of the claim or lawsuit, the matters alleged, and whether the claim or lawsuit is still pending or the manner in which it was resolved; and
 - v. The licensee has any condition that may impair the licensee's ability to practice homeopathic medicine safely and skillfully and if so, the nature of the condition and any accommodations necessary;
 - vi. The licensee has been charged or arrested with any felony or misdemeanor involving moral turpitude as required under A.R.S. § 32-3208.
 2. A list of the treatment modalities the licensee makes available under the licensee's supervision;
 3. If the licensee uses an experimental form of diagnosis or treatment in the licensee's practice of medicine, a copy of the written informed consent materials that a patient signs before examination or treatment;
 4. A list of any specialty certifications held by the licensee, the certifying entity, and the date the certification expires;
 5. If the licensee dispenses drugs or devices as part of the licensee's practice of homeopathic medicine:
 - a. The licensee's DEA registration number;
 - b. A statement whether a complaint or legal action has been taken against the licensee by a court or federal or state agency for dispensing a device, drug, or substance and if so, the name and address of the court or federal or state agency and documentation of the action taken; and
 - c. A list of the items dispensed;
 6. An Arizona Statement of Citizenship and documentary evidence of U.S. citizenship or qualified alien status;
 7. An affirmation that the licensee has completed the continuing education required under A.R.S. § 32-2915;
 8. An affirmation that the licensee is in compliance with A.R.S. § 32-3211 regarding medical records;
 9. The license renewal fee prescribed under R4-38-106; and
 10. The licensee's dated signature affirming that the information provided is true, correct, and complete.

~~R4-38-110.~~ ~~Repealed~~

~~R4-38-108.~~ ~~R4-38-110.~~ Notification of Address Changes Change in Contact Information

The Board shall communicate with a licensee using the most recent contact information provided to the Board. To ensure timely communication from the Board, A a licensee shall advise the Board in writing within 45 days of opening an additional office address, or a change in name, office or residential address, change in home address, or change in telephone number.

~~R4-38-109.~~ ~~R4-38-111.~~ Experimental Forms of Diagnosis and Treatment

- A. No change
- B. No change
 1. No change
 2. No change
 3. No change
- C. No change
 1. No change

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2. No change
3. No change
4. No change
5. No change

~~R4-38-112.~~ Registering Use of Experimental Forms of Diagnosis and Treatment

As part of an initial licensing application and subsequent annual renewal application, an applicant shall designate on a form provided by the Board the modalities of treatment used in the applicant's practice and forms of diagnosis and treatment used by the applicant that are defined as experimental by R4-38-109.

~~R4-38-111.~~ R4-38-112. Peer Review

- A. No change
- B. No change
- C. No change
- D. No change

R4-38-113. Chelation Therapy Practice Requirements

- A. Before a licensee may practice chelation therapy for other than the treatment of metal poisoning, the licensee:
 1. Shall document completion of the postgraduate education required in ~~R4-38-103(C)(2)~~ R4-38-104(C)(2); and
 2. ~~File a sample Submit to and obtain approval from the Board of the informed patient consent form and obtain approval of written disclosure from the Board as required by A.R.S. § 32-2933(27).~~ As part of the documentation submitted with the informed patient consent form, the licensee shall include a copy of the chelation therapy protocol.
- B. ~~If the Board approves the written disclosure under A.R.S. § 32-2933(27), the licensee may practice chelation therapy. The~~ A licensee shall ensure that detailed records and periodic analysis of results on patients consistent with the most recent informed consent and protocol on file with the Board are maintained consistent with A.R.S. § 32-2933(27) and available for periodic review by a peer review committee designated by the Board. ~~Retention The licensee shall ensure that retention of patient medical and treatment records shall also conform with~~ to the requirements of A.R.S. § ~~32-2936~~ 32-2936.

R4-38-115. Use of Title and Abbreviation

- A. The use of the abbreviation "M.D.(H.)" or "D.O.(H.)" (with or without periods), is equivalent to the written designation, "Doctor of Medicine (Homeopathic)" or "Doctor of Osteopathy (Homeopathic)."
- B. A ~~Homeopathic~~ homeopathic physician practicing in this state who is not licensed by the Arizona Board of Medical Examiners or the Arizona Board of Osteopathic Examiners in Medicine and Surgery shall not use any designation other than the initials ~~MD M.D.(H.) or DO D.O.(H.)~~ (with or without periods) to indicate a doctoral degree, ~~which shall be followed by the full, written designation, "Homeopathic Physician."~~
- C. A physician licensed by the Board and ~~any state the~~ Arizona Board of Medical Examiners or the Board and ~~any state the~~ Arizona Board of Osteopathic Examiners in Medicine and Surgery shall use ~~one of the following designations, M.D., M.D.(H.) or D.O., D.O.(H.)~~ as appropriate (with or without periods):
 1. "MD, MD(H)" or "DO, MD(H);"
 2. "MD, Homeopathic Physician" or "DO, Doctor of Medicine (Homeopathic)."
 3. "MD, Doctor of Medicine (Homeopathic)" or "DO, Doctor of Medicine (Homeopathic)."
- D. A licensee practicing in this state shall display the license issued by the Board or an official duplicate of the license in a conspicuous location in the reception area of each office facility.

R4-38-116. Continuing Education Requirement

- A. Under A.R.S. § 32-2915(F), a licensee shall complete at least 20 hours of Board-approved continuing education in the 12 months before submitting the license renewal materials required under R4-38-109. If a licensee completes more than 20 hours of continuing education during a year, the licensee shall not report the extra hours in a subsequent year.
- B. A licensee shall ensure that the licensee obtains and maintains for two years documentary evidence of complying with the continuing education requirement.
- C. An hour of continuing education consists of 60 minutes of participation unless specified otherwise in subsection (D).
- D. The Board approves the following continuing education without application under R4-38-117:
 1. An internship, residency, or fellowship at a teaching institution approved by the American Medical Association, Association of American Medical Colleges, or American Osteopathic Association. A licensee may claim one hour of continuing education for each day of participation in a full-time approved internship, residency, or fellowship and a pro-rata amount of continuing education for each day of participation in an internship, residency, or fellowship that is not full-time. For the purpose of this subsection, the teaching institution at which the approved internship, residency, or fellowship is offered defines "full-time".
 2. An educational program leading to an advanced degree in a medical or medically-related field at a teaching institution approved by the American Medical Association, Association of American Medical Colleges, or American Osteopathic Association. A licensee may claim one hour of continuing education for each day of participation in a full-time

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approved educational program and a pro-rata amount of continuing education for each day of participation in an approved educational program that is not full-time. For the purpose of this subsection, the teaching institution at which the approved educational program is offered defines "full-time":

3. Participating in research at a teaching institution approved by the American Medical Association, Association of American Medical Colleges, or American Osteopathic Association. A licensee may claim one hour of continuing education for each day of full-time research and a pro-rata amount of continuing education for each day of research that is not full-time. For the purpose of this subsection, the teaching institution at which the research is conducted defines "full-time":
4. An educational program certified as Category 1 by an organization accredited by the Accreditation Council for Continuing Medical Education or the American Osteopathic Association;
5. A medical education program designed to provide understanding of current developments, skills, procedures, or treatments related to the practice of medicine and provided by an organization or institution accredited by the Accreditation Council for Continuing Medical Education or the American Osteopathic Association; and
6. A homeopathic medical education course approved or offered by the Council on Homeopathic Education.

E. The Board approves the following activities as continuing education without application under R4-38-117 subject to the specified limitations:

1. Serving as an instructor of medical students, house staff, other physicians, or allied health professionals from a hospital or other health care institution if serving as an instructor provides the licensee with an understanding of current developments, skills, procedures, or treatments related to the practice of allopathic, osteopathic, or homeopathic medicine. A licensee who serves as an instructor:
 - a. May claim one hour of continuing education for each hour of instruction to a maximum of 10; and
 - b. If the licensee teaches substantially the same class more than once, may claim hours of continuing education only for the first time the class is taught;
2. Publishing or presenting a paper, report, or book that deals with current developments, skills, procedures, or treatments related to the practice of allopathic, osteopathic, or homeopathic medicine. A licensee who publishes or presents a paper, report, or book:
 - a. May claim one hour of continuing education for each hour preparing, writing, and presenting to a maximum of 10; and
 - b. May claim hours of continuing education only after the date of publication or presentation; and
3. Participating in the following activities if the participation provides the licensee with an understanding of current developments, skills, procedures, or treatments related to the practice of allopathic, osteopathic, or homeopathic medicine. A licensee may claim one hour continuing education for each hour of participation in the following activities to a maximum of six:
 - a. Completing a self-instructed medical education program through the use of videotape, audiotape, film, filmstrip, radio broadcast, or computer;
 - b. Reading scientific journals and books;
 - c. Preparing for and obtaining specialty board certification or recertification; and
 - d. Participating on a staff or quality of care committee or utilization review committee in a hospital, health care institution, or government agency.

F. The Board shall approve another program or activity as continuing education if the provider of the program or activity makes application under R4-38-117 and the Board determines that the program or activity:

1. Is designed to provide the participant with:
 - a. Understanding of current developments, procedures, or treatments related to the practice of homeopathic medicine as defined at A.R.S. § 32-2901(22);
 - b. Knowledge and skills used to practice homeopathic medicine safely and competently; or
 - c. Knowledge and skills related directly or indirectly to patient care including practice management, medical ethics, or language necessary to the patient population served;
2. Includes a method by which the participant evaluates the:
 - a. Stated objectives of the program or activity;
 - b. Instructor knowledge and teaching ability;
 - c. Effectiveness of the teaching methods used; and
 - d. Usefulness or applicability of the information provided; and
3. Provides the participant with a certificate of attendance that shows the:
 - a. Name of the participant;
 - b. Name of the approved continuing education;
 - c. Name of the continuing education provider;
 - d. Date, time, and location of the continuing education; and
 - e. Hours of instruction provided.

G. Except as specified in subsection (H), a licensee who fails to comply with subsection (A) may submit to the Board a

notice of 60-day extension. The licensee shall submit the notice of 60-day extension no later than the date specified in R4-38-109(B). If a licensee who submits a notice of 60-day extension fails to comply with the continuing education requirement within the extension period, the licensee's license expires and the licensee shall immediately cease practicing homeopathic medicine. A licensee whose license expires may obtain licensure only by complying again with R4-38-108 and taking the examination specified in R4-38-107.

- H.** If a licensee fails to comply with subsection (A) because of disability, military service, absence from the U.S., or other circumstance beyond the control of the licensee, the licensee may submit to the Board a request for a waiver of the continuing education requirement that includes the reason for noncompliance, the number of hours of continuing education completed, and the time requested to become compliant. The licensee shall submit the request for waiver no later than the date specified in R4-38-109(B). The Board shall evaluate the request for waiver and provide written notice to the licensee of the time within which the licensee shall comply with subsection (A).

R4-38-117. Application for Approval of a Continuing Education

- A.** To obtain Board approval of a continuing education under R4-38-116(F), the provider of the continuing education shall submit the following to the Board at least 10 days before the meeting at which the Board will consider the continuing education for approval:
1. An application for approval, using a form available from the Board, which contains the following information:
 - a. Title of the continuing education;
 - b. Name and address of the continuing education provider;
 - c. Name and telephone and fax numbers of the contact person for the continuing education provider;
 - d. Date, time, and place at which the continuing education will be taught, if known;
 - e. Subject matter of the continuing education;
 - f. Objective of the continuing education;
 - g. Method of instruction; and
 - h. Number of continuing education hours requested; and
 2. The following documents:
 - a. Curriculum vitae of the continuing education instructor.
 - b. Detailed outline of the continuing education.
 - c. Agenda for the continuing education showing hours of instruction and subject matter taught in each hour.
 - d. Method by which participants will evaluate the continuing education, and
 - e. Certificate of attendance that meets the requirements at R4-38-116(F)(3).
- B.** A provider of continuing education shall not advertise that a continuing education is approved until the Board acts on the application submitted under subsection (A).
- C.** The Board's approval of a continuing education is valid for one year or until there is a change in subject matter, instructor, or hours of instruction. At the end of one year or when there is a change in subject matter, instructor, or hours of instruction, the provider of the continuing education shall reapply for approval.

R4-38-118. Audit of Compliance and Sanction for Noncompliance with Continuing Education Requirement

- A.** When notice of the need to renew a license is provided under R4-38-109(A), the Board shall also provide notice of an audit of continuing education records to a random sample of licensees.
- B.** A licensee subject to a continuing education audit shall submit documentary evidence of compliance with the continuing education requirement at the same time that the licensee submits the renewal application required under R4-38-109(E).
- C.** If a licensee subject to a continuing education audit fails to submit the required evidence no later than the date specified in R4-38-109(C), the licensee is considered to have committed an act of unprofessional conduct and is subject to probation or license suspension or revocation.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

Editor's Note: The following Notice of Proposed Rulemaking was reviewed per Laws 2010, Ch. 287, § 18. (See the text of § 18 on page 515.) The Governor's Office authorized the notice to proceed through the rulemaking process on February 28, 2011.

[R11-27]

PREAMBLE

- 1. Sections Affected**

R9-22-101 R9-22-201 R9-22-202 R9-22-204 R9-22-210 R9-22-210.01 R9-22-211 R9-22-215 R9-22-217 R9-22-703 R9-22-712	Rulemaking Action Amend Amend Amend Amend Amend Amend Amend Amend Amend Amend
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- 2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**

Authorizing statute: A.R.S. §§ 36-2903.01, 36-2907
Implementing statute: A.R.S. § 36-2907
- 3. A list of all previous notices appearing in the Register addressing the proposed rule:**

Notice of Rulemaking Docket Opening: 17 A.A.R. 513, April 8, 2011 (*in this issue*)
- 4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name: Address: Telephone: Fax: E-mail:	Mariaelena Ugarte AHCCCS Office of Administrative Legal Services 701 E. Jefferson St., Mail Drop 6200 Phoenix, AZ 85034 (602) 417-4693 (602) 253-9115 AHCCCSRules@azahcccs.gov
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- 5. An explanation of the rule, including the agency's reasons for initiating the rule:**

The proposed rules will eliminate the requirement for obtaining PA for services such as, but not limited to: dialysis shunt placement, apnea management and training for premature babies up to one year of life, certain eye surgeries, and hospitalizations for labor and delivery not exceeding specific time parameters. In addition, technical changes and striking of redundant rules will be made.
- 6. A reference to any study relevant to the rules that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

A study was not relied upon for purposes of this rulemaking.
- 7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:**

Not applicable
- 8. The preliminary summary of the economic, small business, and consumer impact:**

The AHCCCS Administration believes that subjecting the identified services to PA adds administrative costs and time-consuming processes to Agency operations, further straining limited program resources without accompanying

Notices of Proposed Rulemaking

benefits. This amendment also reduces the administrative burden on health care providers and facilitates members' access to appropriate care.

Currently 95 percent of the cases are approved. The Administration believes that removal of this requirement will save the provider time and money. Each PA takes 10 minutes and each biller is making approximately \$15 an hour, possibly saving providers \$14,000 in a year. The Administration will also save time and money for the cost of the PA nurse's time, estimated to be \$28,000 a year.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Name: Mariaelena Ugarte
Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson St., Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4693
Fax: (602) 253-9115
E-mail: AHCCCSRules@azahcccs.gov

Proposed rule language will be available on the AHCCCS web site www.azahcccs.gov the week of March 21, 2011. Please send written comments to the above address by 5:00 p.m., May 10, 2011. E-mail comments will also be accepted during this time-frame.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: May 10, 2011
Time: 2:00 p.m.
Location: AHCCCS
701 E. Jefferson St.
Phoenix, AZ 85034
Nature: Public Hearing

Date: May 10, 2011
Time: 2:00 p.m.
Location: ALTCS: Arizona Long-term Care System
1010 N. Finance Center Drive, Suite 201
Tucson, AZ 85710
Nature: Public Hearing

Date: May 10, 2011
Time: 2:00 p.m.
Location: DAHL /Office of Special Investigations
2721 N. 4th St., Suite 23
Flagstaff, AZ 86004
Nature: Public Hearing

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

12. Incorporations by reference and their location in the rules:

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ADMINISTRATION**

ARTICLE 1. DEFINITIONS

Section

R9-22-101. Location of Definitions

ARTICLE 2. SCOPE OF SERVICES

Section

R9-22-201. Scope of Services-related Definitions
R9-22-202. General Requirements
R9-22-204. Inpatient General Hospital Services
R9-22-210. Emergency Medical Services for Non-FES Members
R9-22-210.01. Emergency Behavioral Health Services for Non-FES Members
R9-22-211. Transportation Services
R9-22-215. Other Medical Professional Services
R9-22-217. Services Included in the Federal Emergency Services Program

ARTICLE 7. STANDARDS FOR PAYMENTS

Section

R9-22-703. Payments by the Administration
R9-22-712. Reimbursement: General

ARTICLE 1. DEFINITIONS

R9-22-101. Location of Definitions

A. Location of definitions. Definitions applicable to this Chapter are found in the following:

Definition Section or Citation

“Accommodation” R9-22-701
“Act” R9-22-101
“ADHS” R9-22-101
“Administration” A.R.S. § 36-2901
“Adverse action” R9-22-101
“Affiliated corporate organization” R9-22-101
“Aged” 42 U.S.C. 1382c(a)(1)(A) and R9-22-1501
“Aggregate” R9-22-701
“AHCCCS” R9-22-101
“AHCCCS inpatient hospital day or days of care” R9-22-701
“AHCCCS registered provider” R9-22-101
“Ambulance” A.R.S. § 36-2201
“Ancillary department” R9-22-701
“Ancillary service” R9-22-701
“Anticipatory guidance” R9-22-201
“Annual enrollment choice” R9-22-1701
“APC” R9-22-701
“Appellant” R9-22-101
“Applicant” R9-22-101
“Application” R9-22-101
“Assessment” R9-22-1101
“Assignment” R9-22-101
“Attending physician” R9-22-101
“Authorized representative” R9-22-101
“Authorization” R9-22-201
“Auto-assignment algorithm” R9-22-1701
“AZ-NBCCEDP” R9-22-2001
“Baby Arizona” R9-22-1401
“Behavior management services” R9-22-1201

“Behavioral health adult therapeutic home” R9-22-1201
“Behavioral health therapeutic home care services” R9-22-1201
“Behavioral health evaluation” R9-22-1201
“Behavioral health medical practitioner” R9-22-1201
“Behavioral health professional” A.A.C. R9-20-1201
“Behavioral health recipient” R9-22-201
“Behavioral health service” R9-22-1201
“Behavioral health technician” A.A.C. R9-20-1201
“BHS” R9-22-1401
“Billed charges” R9-22-701
“Blind” R9-22-1501
“Burial plot” R9-22-1401
“Business agent” R9-22-701 and R9-22-704
“Calculated inpatient costs” R9-22-712.07
“Capital costs” R9-22-701
“Capped fee-for-service” R9-22-101
“Caretaker relative” R9-22-1401
“Case management” R9-22-1201
“Case record” R9-22-101
“Case review” R9-22-101
“Cash assistance” R9-22-1401
“Categorically eligible” R9-22-101
“CCR” R9-22-712
“Certified psychiatric nurse practitioner” R9-22-1201
“Charge master” R9-22-712
“Child” R9-22-1503 and R9-22-1603
“Children’s Rehabilitative Services” or “CRS” ~~R9-22-201~~ R9-22-101
“Claim” R9-22-1101
“Claims paid amount” R9-22-712.07
“Clean claim” A.R.S. § 36-2904
“Clinical supervision” R9-22-201
“CMDP” R9-22-1701
“CMS” R9-22-101
“Continuous stay” R9-22-101
“Contract” R9-22-101
“Contract year” R9-22-101
“Contractor” A.R.S. § 36-2901
“Copayment” R9-22-701, R9-22-711 and R9-22-1603
“Cost avoid” R9-22-1201
“Cost-To-Charge Ratio” R9-22-701
“Covered charges” R9-22-701
“Covered services” R9-22-101
“CPT” R9-22-701
“Creditable coverage” R9-22-2003 and 42 U.S.C. 300gg(c)
“Critical Access Hospital” R9-22-701
“CRS” R9-22-1401

“Cryotherapy” R9-22-2001
“Customized DME” R9-22-212
“Day” R9-22-101 and R9-22-1101
“Date of the Notice of Adverse Action” R9-22-1441
“DBHS” ~~R9-22-201~~ R9-22-101
“DCSE” R9-22-1401
“De novo hearing” 42 CFR 431.201
“Dentures” and “Denture services” R9-22-201
“Department” A.R.S. § 36-2901
“Dependent child” A.R.S. § 46-101
“DES” R9-22-101
“Diagnostic services” R9-22-101
“Director” R9-22-101
“Disabled” R9-22-1501
“Discussion” R9-22-101
“Disenrollment” R9-22-1701
“DME” R9-22-101
“DRI inflation factor” R9-22-701
“E.P.S.D.T. services” 42 CFR 440.40(b)
“Eligibility posting” R9-22-701
“Eligible person” A.R.S. § 36-2901
“Emergency behavioral health condition for the non-FES member” R9-22-201
“Emergency behavioral health services for the non-FES member” R9-22-201
“Emergency medical condition for the non-FES member” R9-22-201
“Emergency medical services for the non-FES member” R9-22-201
“Emergency medical or behavioral health condition for a FES member” R9-22-217
“Emergency services costs” A.R.S. § 36-2903.07
“Encounter” R9-22-701
“Enrollment” R9-22-1701
“Enumeration” R9-22-101
“Equity” R9-22-101
“Experimental services” R9-22-203
“Existing outpatient service” R9-22-701
“Expansion funds” R9-22-701
“FAA” R9-22-1401
“Facility” R9-22-101
“Factor” R9-22-701 and 42 CFR 447.10
“FBR” R9-22-101
“Federal financial participation” or “FFP” 42 CFR 400.203
“Federal poverty level” or “FPL” A.R.S. § 36-2981
“Fee-For-Service” or “FFS” R9-22-101
“FES member” R9-22-101
“FESP” R9-22-101
“First-party liability” R9-22-1001
“File” R9-22-1101
“Fiscal agent” R9-22-210

“Fiscal intermediary” R9-22-701
“Foster care maintenance payment” 42 U.S.C. 675(4)(A)
“FQHC” R9-22-101
“Free Standing Children’s Hospital” R9-22-701
“Fund” R9-22-712.07
“Graduate medical education (GME) program” R9-22-701
“Grievance” A.A.C. R9-34-202
“GSA” R9-22-101
“HCPCS” R9-22-701
“Health care practitioner” R9-22-1201
“Hearing aid” R9-22-201
“HIPAA” R9-22-701
“Home health services” R9-22-201
“Homebound” R9-22-1401
“Hospital” R9-22-101
“In-kind income” R9-22-1420
“Insured entity” R9-22-720
“Intermediate Care Facility for the Mentally Retarded” or “ICF-MR” 42 U.S.C. 1396d(d)
“ICU” R9-22-701
“IHS” R9-22-101
“IHS enrolled” or “enrolled with IHS” R9-22-708
“IMD” or “Institution for Mental Diseases” 42 CFR 435.1010 and ~~R9-22-201~~ R9-22-101
“Income” R9-22-1401 and R9-22-1603
“Indigent” R9-22-1401
“Individual” R9-22-211
“Inmate of a public institution” 42 CFR 435.1010
“Inpatient covered charges” R9-22-712.07
“Interested party” R9-22-101
“Intermediate Care Facility for the Mentally Retarded” or “ICF-MR” 42 U.S.C. 1396d(d)
“Intern and Resident Information System” R9-22-701
“LEEP” R9-22-2001
“Legal representative” R9-22-101
“Level I trauma center” R9-22-2101
“License” or “licensure” R9-22-101
“Licensee” R9-22-1201
“Liquid assets” R9-22-1401
“Mailing date” R9-22-101
“Medical education costs” R9-22-701
“Medical expense deduction” or “MED” R9-22-1401
“Medical record” R9-22-101
“Medical review” R9-22-701
“Medical services” A.R.S. § 36-401
“Medical supplies” ~~R9-22-201~~ R9-22-101
“Medical support” R9-22-1401
“Medically necessary” R9-22-101
“Medicare claim” R9-22-101

“Medicare HMO” R9-22-101
“Member” A.R.S. § 36-2901
“Mental disorder” A.R.S. § 36-501
“Milliman study” R9-22-712.07
“Monthly equivalent” R9-22-1421 and R9-22-1603
“Monthly income” R9-22-1421 and R9-22-1603
“National Standard code sets” R9-22-701
“New hospital” R9-22-701
“NICU” R9-22-701
“Noncontracted Hospital” R9-22-718
“Noncontracting provider” A.R.S. § 36-2901
“Non-FES member” ~~R9-22-201~~ R9-22-101
“Non-IHS Acute Hospital” R9-22-701
“Nonparent caretaker relative” R9-22-1401
“Notice of Findings” R9-22-109
“Nursing facility” or “NF” 42 U.S.C. 1396r(a)
“OBHL” R9-22-1201
“Observation day” R9-22-701
“Occupational therapy” R9-22-201
“Offeror” R9-22-101
“Operating costs” R9-22-701
“Organized health care delivery system” R9-22-701
“Outlier” R9-22-701
“Outpatient hospital service” R9-22-701
“Ownership change” R9-22-701
“Ownership interest” 42 CFR 455.101
“Parent” R9-22-1603
“Partial Care” R9-22-1201
“Participating institution” R9-22-701
“Peer group” R9-22-701
“Peer-reviewed study” R9-22-2001
“Penalty” R9-22-1101
“Pharmaceutical service” R9-22-201
“Physical therapy” R9-22-201
“Physician” R9-22-101
“Physician assistant” R9-22-1201
“Post-stabilization services” R9-22-201 or 42 CFR 422.113
“PPC” R9-22-701
“PPS bed” R9-22-701
“Practitioner” R9-22-101
“Pre-enrollment process” R9-22-1401
“Premium” R9-22-1603
“Prescription” R9-22-101
“Primary care provider or “PCP” R9-22-101
“Primary care provider services” R9-22-201
“Prior authorization” R9-22-101

“Prior period coverage” or “PPC” R9-22-701
“Procedure code” R9-22-701
“Proposal” R9-22-101
“Prospective rates” R9-22-701
“Psychiatrist” R9-22-1201
“Psychologist” R9-22-1201
“Psychosocial rehabilitation services” R9-22-201
“Public hospital” R9-22-701
“Qualified alien” A.R.S. § 36-2903.03
“Qualified behavioral health service provider” R9-22-1201
“Quality management” R9-22-501
“Radiology” R9-22-101
“RBHA” or “Regional Behavioral Health Authority” R9-22-201
“Reason to know” R9-22-1101
“Rebase” R9-22-701
“Referral” R9-22-101
“Rehabilitation services” R9-22-101
“Reinsurance” R9-22-701
“Remittance advice” R9-22-701
“Resident” R9-22-701
“Residual functional deficit” R9-22-201
“Resources” R9-22-1401
“Respiratory therapy” R9-22-201
“Respite” R9-22-1201
“Responsible offeror” R9-22-101
“Responsive offeror” R9-22-101
“Revenue Code” R9-22-701
“Review” R9-22-101
“Review month” R9-22-101
“RFP” R9-22-101
“Rural Contractor” R9-22-718
“Rural Hospital” R9-22-712.07 and R9-22-718
“Scope of services” R9-22-201
“Section 1115 Waiver” A.R.S. § 36-2901
“Service location” R9-22-101
“Service site” R9-22-101
“SOBRA” R9-22-101
“Specialist” R9-22-101
“Specialty facility” R9-22-701
“Speech therapy” R9-22-201
“Spendthrift restriction” R9-22-1401
“Sponsor” R9-22-1401
“Sponsor deemed income” R9-22-1401
“Sponsoring institution” R9-22-701
“Spouse” R9-22-101
“SSA” 42 CFR 1000.10

“SSDI Temporary Medical Coverage” R9-22-1603
“SSI” 42 CFR 435.4
“SSN” R9-22-101
“Stabilize” 42 U.S.C. 1395dd
“Standard of care” R9-22-101
“Sterilization” R9-22-201
“Subcontract” R9-22-101
“Submitted” A.R.S. § 36-2904
“Substance abuse” R9-22-201
“SVES” R9-22-1401
“Therapeutic foster care services” R9-22-1201
“Third-party” R9-22-1001
“Third-party liability” R9-22-1001
“Tier” R9-22-701
“Tiered per diem” R9-22-701
“Title IV-D” R9-22-1401
“Title IV-E” R9-22-1401
“Total Inpatient payments” R9-22-712.07
“Trauma and Emergency Services Fund” A.R.S. § 36-2903.07
“TRBHA” or “Tribal Regional Behavioral Health Authority” R9-22-1201
“Treatment” R9-22-2004
“Tribal Facility” A.R.S. § 36-2981
“Unrecovered trauma center readiness costs” R9-22-2101
“Urban Contractor” R9-22-718
“Urban Hospital” R9-22-718
“USCIS” R9-22-1401
“Utilization management” R9-22-501
“WWHP” R9-22-2001

B. General definitions. In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

“Act” means the Social Security Act.

“ADHS” means the Arizona Department of Health Services.

“Adverse action” means an action taken by the Department or Administration to deny, discontinue, or reduce medical assistance.

“Affiliated corporate organization” means any organization that has ownership or control interests as defined in 42 CFR 455.101, and includes a parent and subsidiary corporation.

“AHCCCS” means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to a member.

“AHCCCS registered provider” means a provider or noncontracting provider who:

Enters into a provider agreement with the Administration under R9-22-703(A), and

Meets license or certification requirements to provide covered services.

“Appellant” means an applicant or member who is appealing an adverse action by the Department or Administration.

“Applicant” means a person who submits or whose authorized representative submits a written, signed, and dated application for AHCCCS benefits.

“Application” means an official request for AHCCCS medical coverage made under this Chapter.

“Assignment” means enrollment of a member with a contractor by the Administration.

“Attending physician” means a licensed allopathic or osteopathic doctor of medicine who has primary responsibility for providing or directing preventive and treatment services for a Fee-For-Service member.

“Authorized representative” means a person who is authorized to apply for medical assistance or act on behalf of another person.

“Capped fee-for-service” means the payment mechanism by which a provider of care is reimbursed upon submission of a valid claim for a specific covered service or equipment provided to a member. A payment is made in accordance with an upper or capped limit established by the Director. This capped limit can either be a specific dollar amount or a percentage of billed charges.

“Case record” means an individual or family file retained by the Department that contains all pertinent eligibility information, including electronically stored data.

“Case review” means the Administration’s evaluation of an individual’s or family’s circumstances and case record in a review month.

“Categorically eligible” means a person who is eligible under A.R.S. §§ 36-2901(6)(a)(i), (ii), or (iii) or 36-2934.

“Children’s Rehabilitative Services” or “CRS” means the program within ADHS that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.

“CMS” means the Centers for Medicare and Medicaid Services.

“Continuous stay” means a period during which a member receives inpatient hospital services without interruption beginning with the date of admission and ending with the date of discharge or date of death.

“Contract” means a written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29, and this Chapter.

“Contract year” means the period beginning on October 1 of a year and continuing until September 30 of the following year.

“Covered services” means the health and medical services described in Articles 2 and 12 of this Chapter as being eligible for reimbursement by AHCCCS.

“Day” means a calendar day unless otherwise specified.

“DBHS” means the Division of Behavioral Health Services within the Arizona Department of Health Services.

“DES” means the Department of Economic Security.

“Diagnostic services” means services provided for the purpose of determining the nature and cause of a condition, illness, or injury.

“Director” means the Director of the Administration or the Director’s designee.

“Discussion” means an oral or written exchange of information or any form of negotiation.

“DME” means durable medical equipment, which is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness, or injury.

“Enumeration” means the assignment of a nine-digit identification number to a person by the Social Security Administration.

“Equity” means the county assessor full cash value or market value of a resource minus valid liens, encumbrances, or both.

“Facility” means a building or portion of a building licensed or certified by the Arizona Department of Health Services as a health care institution under A.R.S. Title 36, Chapter 4, to provide a medical service, a nursing service, or other health care or health-related service.

“FBR” means Federal Benefit Rate, the maximum monthly Supplemental Security Income payment rate for a member or a married couple.

“Fee-For-Service” or “FFS” means a method of payment by the AHCCCS Administration to a registered provider on an amount-per-service basis for a member not enrolled with a contractor.

“FES member” means a person who is eligible to receive emergency medical and behavioral health services through the FESP under R9-22-217.

“FESP” means the federal emergency services program under R9-22-217 which covers services to treat an emergency medical or behavioral health condition for a member who is determined eligible under A.R.S. § 36-2903.03(D).

“FQHC” means federally qualified health center.

“GSA” means a geographical service area designated by the Administration within which a contractor provides, directly or through a subcontract, a covered health care service to a member enrolled with the contractor.

“Hospital” means a health care institution that is licensed as a hospital by the Arizona Department of Health Services under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined, by the Arizona Department of Health Services as the CMS designee, to meet the requirements of certification.

“IHS” means Indian Health Service.

“IMD” or “Institution for Mental Diseases” means an Institution for Mental Diseases as described in 42 CFR 435.1010 and licensed by ADHS.

“Interested party” means an actual or prospective offeror whose economic interest may be directly affected by the issuance of an RFP, the award of a contract, or by the failure to award a contract.

“Legal representative” means a custodial parent of a child under 18, a guardian, or a conservator.

“License” or “licensure” means a nontransferable authorization that is granted based on established standards in law by a state or a county regulatory agency or board and allows a health care provider to lawfully render a health care service.

“Mailing date” when used in reference to a document sent first class, postage prepaid, through the United States mail, means the date:

Shown on the postmark;

Shown on the postage meter mark of the envelope, if no postmark; or

Entered as the date on the document, if there is no legible postmark or postage meter mark.

“Medical record” means a document that relates to medical or behavioral health services provided to a member by a physician or other licensed practitioner of the healing arts and that is kept at the site of the provider.

“Medical supplies” means consumable items that are designed specifically to meet a medical purpose.

“Medically necessary” means a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or to prolong life.

“Medicare claim” means a claim for Medicare-covered services for a member with Medicare coverage.

“Medicare HMO” means a health maintenance organization that has a current contract with Centers for Medicare and Medicaid Services for participation in the Medicare program under 42 CFR 417(L).

“Non-FES member” means an eligible person who is entitled to full AHCCCS services.

“Offeror” means an individual or entity that submits a proposal to the Administration in response to an RFP.

“Physician” means a person licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

“Practitioner” means a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a registered nurse practitioner certified under A.R.S. Title 32, Chapter 15.

“Prescription” means an order to provide covered services that is signed or transmitted by a provider authorized to prescribe the services.

“Primary care provider” or “PCP” means an individual who meets the requirements of A.R.S. § 36-2901(12) or (13), and who is responsible for the management of a member’s health care.

“Prior authorization” means the process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services ~~contingent on the medical necessity of the services; based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article and any applicable contract provisions, but is not a guarantee of payment.~~

“Prior period coverage” means the period prior to the member’s enrollment during which a member is eligible for covered services. PPC begins on the first day of the month of application or the first eligible month, whichever is later, and continues until the day the member is enrolled with a contractor.

“Proposal” means all documents, including best and final offers, submitted by an offeror in response to an RFP by the Administration.

“Radiology” means professional and technical services rendered to provide medical imaging, radiation oncology, and radioisotope services.

“Referral” means the process by which a member is directed by a primary care provider or an attending physician to another appropriate provider or resource for diagnosis or treatment.

“Rehabilitation services” means physical, occupational, and speech therapies, and items to assist in improving or

restoring a person's functional level.

"Responsible offeror" means an individual or entity that has the capability to perform the requirements of a contract and that ensures good faith performance.

"Responsive offeror" means an individual or entity that submits a proposal that conforms in all material respects to an RFP.

"Review" means a review of all factors affecting a member's eligibility.

"Review month" means the month in which the individual's or family's circumstances and case record are reviewed.

"RFP" means Request for Proposals, including all documents, whether attached or incorporated by reference, that are used by the Administration for soliciting a proposal under 9 A.A.C. 22, Article 6.

"Service location" means a location at which a member obtains a covered service provided by a physician or other licensed practitioner of the healing arts under the terms of a contract.

"Service site" means a location designated by a contractor as the location at which a member is to receive covered services.

"S.O.B.R.A." means Section 9401 of the Sixth Omnibus Budget Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396a(a)(10)(A)(i)(IV), 42 U.S.C. 1396a(a)(10)(A)(i)(VI), and 42 U.S.C. 1396a(a)(10)(A)(i)(VII).

"Specialist" means a Board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

"Spouse" means a person who has entered into a contract of marriage recognized as valid by this state.

"SSN" means Social Security number.

"Standard of care" means a medical procedure or process that is accepted as treatment for a specific illness, injury, or medical condition through custom, peer review, or consensus by the professional medical community.

"Subcontract" means an agreement entered into by a contractor with any of the following:

A provider of health care services who agrees to furnish covered services to a member,

A marketing organization, or

Any other organization or person that agrees to perform any administrative function or service for the contractor specifically related to securing or fulfilling the contractor's obligation to the Administration under the terms of a contract.

ARTICLE 2. SCOPE OF SERVICES

R9-22-201. Scope of Services-related Definitions

In addition to definitions contained in A.R.S. § 36-2901, the words and phrases in this Chapter have the following meanings unless the context explicitly requires another meaning:

"Anticipatory guidance" means a person responsible for a child receives information and guidance of what the person should expect of the child's development and how to help the child stay healthy.

"Behavioral health recipient" means a Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through ADHS/DBHS.

~~"Children's Rehabilitative Services" or "CRS" means the program within ADHS that provides covered medical services and covered support services in accordance with A.R.S. § 36-261.~~

"Clinical supervision" means a Clinical Supervisor under 9 A.A.C. 20, Article 2 reviews the skills and knowledge of the individual supervised and provides guidance in improving or developing the skills and knowledge.

~~"DBHS" means the Division of Behavioral Health Services within the Arizona Department of Health Services.~~

"Emergency behavioral health condition for ~~the~~ a non-FES member" means a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

Placing the health of the person, including mental health, in serious jeopardy;

Serious impairment to bodily functions;

Serious dysfunction of any bodily organ or part; or

Serious physical harm to another person.

"Emergency behavioral health services for ~~the~~ non-FES member" means those behavioral health services provided

for the treatment of an emergency behavioral health condition.

“Emergency medical condition for ~~the a~~ non-FES member” means treatment for a medical condition, including labor and delivery, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the member’s health in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

“Emergency medical services for ~~the~~ non-FES member” means services provided for the treatment of an emergency medical condition.

“Hearing aid” means an instrument or device designed for, or represented by the supplier as aiding or compensating for impaired or defective human hearing, and includes any parts, attachments, or accessories of the instrument or device.

“Home health services” means services and supplies that are provided by a home health agency that coordinates in-home intermittent services for curative, habilitative care, including home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances.

~~“IMD” or “Institution for Mental Diseases” means an Institution for Mental Diseases as described in 42 CFR 435.1010 and licensed by ADHS.~~

~~“Medical supplies” means consumable items that are designed specifically to meet a medical purpose.~~

~~“Non-FES member” means an eligible person who is entitled to full AHCCCS services.~~

“Occupational therapy” means medically prescribed treatment provided by or under the supervision of a licensed occupational therapist, to restore or improve an individual’s ability to perform tasks required for independent functioning.

“Pharmaceutical service” means medically necessary medications that are prescribed by a physician, practitioner, or dentist under R9-22-209.

“Physical therapy” means treatment services to restore or improve muscle tone, joint mobility, or physical function provided by or under the supervision of a registered physical therapist.

“Post-stabilization services” means covered services related to an emergency medical or behavioral health condition provided after the condition is stabilized.

“Primary care provider services” means healthcare services provided by and within the scope of practice, as defined by law, of a licensed physician, certified nurse practitioner, or licensed physician assistant.

“Psychosocial rehabilitation services” means services that provide education, coaching, and training to address or prevent residual functional deficits and may include services that may assist a member to secure and maintain employment. Psychosocial rehabilitation services may include:

- Living skills training,
- Cognitive rehabilitation,
- Health promotion,
- Supported employment, and
- Other services that increase social and communication skills to maximize a member’s ability to participate in the community and function independently.

“RBHA” or “Regional Behavioral Health Authority” means the same as in A.R.S. § 36-3401.

“Residual functional deficit” means a member’s inability to return to a previous level of functioning, usually after experiencing a severe psychotic break or state of decompensation.

“Respiratory therapy” means treatment services to restore, maintain, or improve respiratory functions that are provided by, or under the supervision of, a respiratory therapist licensed according to A.R.S. Title 32, Chapter 35.

“Scope of services” means the covered, limited, and excluded services under Articles 2 and 12 of this Chapter.

“Speech therapy” means medically prescribed diagnostic and treatment services provided by or under the supervision of a certified speech therapist.

“Sterilization” means a medically necessary procedure, not for the purpose of family planning, to render an eligible person or member barren in order to:

- Prevent the progression of disease, disability, or adverse health conditions; or

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Prolong life and promote physical health.

“Substance abuse” means the chronic, habitual, or compulsive use of any chemical matter that, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse for adults who are 21 years of age or older.

R9-22-202. General Requirements

- A.** For the purposes of this Article, the following definitions apply:
1. “Authorization” means ~~written or verbal~~ written, verbal or electronic authorization by:
 - a. The Administration for services rendered to a fee-for-service member, or
 - b. The contractor for services rendered to a prepaid capitated member.
 2. Use of the phrase “attending physician” applies only to the fee-for-service population.
- B.** In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:
1. Only medically necessary, cost effective, and federally-reimbursable and state-reimbursable services are covered services.
 2. Covered services for the federal emergency services program (FESP) are under R9-22-217.
 3. The Administration or a contractor may waive the covered services referral requirements of this Article.
 4. Except as authorized by the Administration or a contractor, a primary care provider, attending physician, practitioner, or a dentist shall provide or direct the member’s covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
 5. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor’s network without a referral from a primary care provider.
 6. ~~A member may receive behavioral health evaluation services without a referral from a primary care provider. A member may receive behavioral health treatment services only under referral from the primary care provider or upon authorization by the contractor or the contractor’s designee. A member may receive behavioral health services as specified in Article 2 and Article 12.~~
 7. AHCCCS or a contractor shall provide services under the Section 1115 Waiver as defined in A.R.S. § 36-2901.
 8. An AHCCCS registered provider shall provide covered services within the provider’s scope of practice.
 9. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
 - a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
 - b. Services or items furnished gratuitously, and
 - c. Personal care items except as specified under R9-22-212.
 10. Medical or behavioral health services are not covered services if provided to:
 - a. An inmate of a public institution;
 - b. A person who is in residence at an institution for the treatment of tuberculosis; or
 - c. A person age 21 through 64 who is in an IMD, unless the service is covered under Article 12 of this Chapter.
- C.** ~~The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained as specified in this Article and Article 7 of this Chapter. Failure to obtain prior authorization as specified in this Article and Article 7 of this Chapter is a basis for denial of payment for non-emergency services.~~ The Administration or a contractor shall not ~~reimburse services that require~~ provide prior authorization for services unless the provider submits documentation of documents the diagnosis and the medical necessity of the treatment along with the prior authorization request.
- D.** Services under A.R.S. § 36-2908 provided during the prior period coverage do not require prior authorization.
- E.** Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.
- F.** A service is not a covered service if provided outside the GSA unless one of the following applies:
1. A member is referred by a primary care provider for medical specialty care outside the GSA. If a member is referred outside the GSA to receive an authorized medically necessary service, the contractor shall also provide all other medically necessary covered services for the member;
 2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member’s family;
 3. The contractor authorizes placement in a nursing facility located out of the GSA; or
 4. Services are provided during prior period coverage.
- G.** If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.
- H.** A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.

- I. The Administration shall determine the circumstances under which a FFS member may receive services, other than emergency services, from service providers outside the member's county of residence or outside the state. Criteria considered by the Administration in making this determination shall include availability and accessibility of appropriate care and cost effectiveness.
- J. The restrictions, limitations, and exclusions in this Article do not apply to the following:
 - 1. Public and private employers selecting AHCCCS as a health care option for their employees according to 9 A.A.C. 27~~;~~ and
 - 2. A contractor electing to provide noncovered services.
 - a. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
 - b. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.
- K. Subject to CMS approval, the restrictions, limitations, and exclusions specified in the following subsections do not apply to American Indians receiving services through IHS or a tribal health program operating under P.L. 93-638 when those services are eligible for one hundred percent federal financial participation:
 - 1. R9-22-205(A)(8)
 - 2. R9-22-205(B)(4)(f)
 - 3. R9-22-206
 - 4. R9-22-207
 - 5. R9-22-212(C)
 - 6. R9-22-212(D)
 - 7. R9-22-212(E)(8)
 - 8. R9-22-215(C)(2)
 - 9. R9-22-215(C)(5)

R9-22-204. Inpatient General Hospital Services

- A. A contractor, fee-for-service provider or noncontracting provider shall render inpatient general hospital services including:
 - 1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
 - a. Maternity care, including labor, delivery, and recovery room, birthing center, and newborn nursery;
 - b. Neonatal intensive care unit (NICU);
 - c. Intensive care unit (ICU);
 - d. Surgery, including surgery room and recovery room;
 - e. Nursery and related services;
 - f. Routine care; and
 - g. Emergency behavioral health services provided under Article 12 of this Chapter for a member eligible under A.R.S. § 36-2901(6)(a).
 - 2. Ancillary services as specified by the Director and included in contract:
 - a. Laboratory services;
 - b. Radiological and medical imaging services;
 - c. Anesthesiology services;
 - d. Rehabilitation services;
 - e. Pharmaceutical services and prescription drugs;
 - f. Respiratory therapy;
 - g. Blood and blood derivatives; and
 - h. Central supply items, appliances, and equipment that are not ordinarily furnished to all patients and customarily reimbursed as ancillary services.
- B. The following limitations apply to inpatient general hospital services that are provided by FFS providers.
 - 1. Providers shall obtain prior authorization from the Administration for the following inpatient hospital services:
 - a. Nonemergency and elective admission, including psychiatric hospitalization;
 - ~~b. Elective surgery, excluding a voluntary sterilization procedure. Voluntary sterilization procedure does not require prior authorization; and~~
 - b. Elective surgery; and
 - c. Services or items provided to cosmetically reconstruct or improve personal appearance after an illness or injury.
 - 2. Providers are not required to obtain prior authorization from the Administration for the following inpatient hospital services:
 - a. Voluntary sterilization.
 - b. Dialysis shunt placement.
 - c. Arteriovenous graft placement for dialysis.

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- d. Angioplasties or thrombectomies of dialysis shunts.
 - e. Angioplasties or thrombectomies of arteriovenous graft for dialysis.
 - f. Hospitalization for vaginal delivery that does not exceed 48 hours.
 - g. Hospitalization for cesarean section delivery that does not exceed 96 hours, and
 - h. Other services identified by the Administration through the Provider Participation Agreement.
- 2-3. The Administration may perform concurrent review for hospitalizations of non-FES members to determine whether there is medical necessity for the hospitalization.
- a. ~~A provider shall notify the Administration no later than the fourth day of hospitalization after an emergency admission or no later than the second day after an intensive care unit admission so that the Administration may initiate concurrent review of the hospitalization.~~
 - a. A provider shall notify the Administration no later than 72 hours after an emergency admission.
 - b. Failure of the provider to obtain prior authorization is cause for denial of a claim.

R9-22-210. Emergency Medical Services for Non-FES Members

A. General provisions.

1. Applicability. This Section applies to emergency medical services for non-FES members. Provisions regarding emergency behavioral health services for non-FES members are in R9-22-210.01. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definitions.
 - a. For the purposes of this Section, “contractor” has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS, or a subcontractor of ADHS/DBHS, or Children’s Rehabilitative Services.
 - b. For the purposes of this Section and R9-22-210.01, “fiscal agent” means a person who bills and accepts payment for a hospital or emergency room provider.
3. Verification. A provider of emergency medical services shall verify a person’s eligibility status with AHCCCS, and if eligible, determine whether the person is enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor.
4. Prior authorization.
 - a. Emergency medical services. ~~Prior authorization is not required for emergency medical services for non-FES members. A provider is not required to obtain prior authorization for emergency medical services.~~
 - b. Non-emergency medical services. If a non-FES member’s medical condition does not require emergency medical services, the provider shall obtain prior authorization as required by the terms of the provider agreement under R9-22-714(A) or the provider’s subcontract with the contractor, whichever is applicable.
5. Prohibition against denial of payment. ~~Neither the Administration and nor a contractor shall; not limit or deny payment for emergency medical services for the following reasons:~~
 - a. ~~On the basis of lists of diagnoses or symptoms;~~
 - b. ~~Prior authorization was not obtained, or~~
 - e. ~~The provider does not have a subcontract.~~
 - a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
 - b. Deny or limit payment because the provider failed to obtain prior authorization for emergency services.
 - c. Deny or limit payment because the provider does not have a subcontract.
6. Grounds for denial. The Administration and a contractor may deny payment for emergency medical services for reasons including but not limited to:
 - a. The claim was not a clean claim;
 - b. The claim was not submitted timely; and
 - c. The provider failed to provide timely notification under subsection (B)(4) to the contractor or the Administration, as appropriate, and the contractor does not have actual notice from any other source that the member has presented for services.

B. Additional requirements for emergency medical services for non-FES members enrolled with a contractor.

1. Responsible entity. A contractor is responsible for the provision of all emergency medical services to non-FES members enrolled with the contractor.
2. Prohibition against denial of payment. A contractor shall not limit or deny payment for emergency medical services when an employee of the contractor instructs the member to obtain emergency medical services.
3. Notification. A contractor shall not deny payment to a hospital, emergency room provider, or fiscal agent for an emergency medical service rendered to a non-FES member based on the failure of the hospital, emergency room provider, or fiscal agent to notify the member’s contractor within 10 days from the day that the member presented for the emergency medical service.
4. Contractor notification. A hospital, emergency room provider, or fiscal agent shall notify the contractor no later than the 11th day after presentation of the non-FES member for emergency inpatient medical services. A contractor may deny payment for a hospital’s, emergency room provider’s, or fiscal agent’s failure to provide timely notice.

C. Post-stabilization services for non-FES members enrolled with a contractor.

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1. After the emergency medical condition of a member enrolled with a contractor is stabilized, a provider shall request prior authorization from the contractor for post-stabilization services.
2. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that have been prior authorized by the contractor.
3. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor for prior authorization of further post-stabilization services;
4. The contractor is financially responsible for medical post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, but are administered to maintain, improve, or resolve the member's stabilized condition if:
 - a. The contractor does not respond to a request for prior authorization within one hour;
 - b. The contractor authorized to give the prior authorization cannot be contacted; or
 - c. The contractor representative and the treating physician cannot reach an agreement concerning the member's care and the contractor physician is not available for consultation. In this situation, the contractor shall give the treating physician the opportunity to consult with a contractor physician. The treating physician may continue with care of the member until the contractor physician is reached or:
 - i. A contractor physician with privileges at the treating hospital assumes responsibility for the member's care;
 - ii. A contractor physician assumes responsibility for the member's care through transfer;
 - iii. The contractor's representative and the treating physician reach agreement concerning the member's care;or
 - iv. The member is discharged.
5. Transfer or discharge. The attending physician or practitioner actually treating the member for the emergency medical condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor.

D. Additional requirements for FFS members.

1. Responsible entity. The Administration is responsible for the provision of all emergency medical services to non-FES FFS members.
2. Grounds for denial. The Administration may deny payment for emergency medical services if a provider fails to provide timely notice to the Administration.
3. Notification. A provider shall notify the Administration no later than 72 hours after a FFS member receiving emergency medical services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.

R9-22-210.01. Emergency Behavioral Health Services for Non-FES Members

A. General provisions.

1. Applicability. This Section applies to emergency behavioral health services for non-FES members. Provisions regarding emergency medical services for non-FES members are in R9-22-210. Provisions regarding emergency medical and behavioral health services for FES members are in R9-22-217.
2. Definition. For the purposes of this Section, "contractor" has the same meaning as in A.R.S. § 36-2901. Contractor does not include ADHS/DBHS, a subcontractor of ADHS/DBHS, or Children's Rehabilitative Services.
3. Responsible entity for inpatient emergency behavioral health services.
 - a. Members enrolled with a contractor.
 - i. ADHS/DBHS. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with the contractor, from one of the following time periods, whichever comes first:
 - (1) The date on which the member becomes a behavioral health recipient; or
 - (2) The ~~seventy-third~~ 73rd hour after admission for inpatient emergency behavioral health services.
 - ii. Contractors. Contractors are responsible for providing inpatient emergency behavioral health services to non-FES members with psychiatric or substance abuse diagnoses who are enrolled with a contractor and are not behavioral health recipients, for the first 72 hours after admission.
 - b. FFS members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all inpatient emergency behavioral health services for non-FES FFS members with psychiatric or substance abuse diagnoses.
4. Responsible entity for non-inpatient emergency behavioral health services for non-FES members. ADHS/DBHS or a subcontractor of ADHS/DBHS is responsible for providing all non-inpatient emergency behavioral health services for non-FES members.
5. Verification. A provider of emergency behavioral health services shall verify a person's eligibility status with AHCCCS, and if eligible, determine whether the person is a member enrolled with AHCCCS as non-FES FFS or is enrolled with a contractor, and determine whether the member is a behavioral health recipient as defined in R9-22-102.

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6. Prior authorization.
 - a. Emergency behavioral health services. ~~Emergency behavioral health services do not require prior authorization. A provider is not required to obtain prior authorization for emergency behavioral health services.~~
 - b. Non-emergency behavioral health services. When a non-FES member's behavioral health condition is determined by the provider not to require emergency behavioral health services, the provider shall follow the prior authorization requirements of a contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.
 7. Prohibition against denial of payment. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS shall not limit or deny payment to an emergency behavioral health provider for emergency behavioral health services to a non-FES member for the following reasons:
 - a. On the basis of lists of diagnoses or symptoms;
 - b. Prior authorization was not obtained;
 - c. The provider does not have a contract;
 - d. An employee of the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS instructs the member to obtain emergency behavioral health services; or
 - e. The failure of a hospital, emergency room provider, or fiscal agent to notify the member's contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS within 10 days from the day the member presented for the emergency service.
 8. Grounds for denial. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS may deny payment for emergency behavioral health services for reasons including but not limited to the following:
 - a. The claim was not a clean claim;
 - b. The claim was not submitted timely; or
 - c. The provider failed to provide timely notification to the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.
 9. Notification. A hospital, emergency room provider, or fiscal agent shall notify a contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, whichever is appropriate, no later than the 11th day from presentation of the non-FES member for emergency inpatient behavioral health services.
 10. Behavioral health evaluation. An emergency behavioral health evaluation is covered as an emergency behavioral health service for a non-FES member under this Section if:
 - a. Required to evaluate or stabilize an acute episode of mental disorder or substance abuse; and
 - b. Provided by a qualified provider who is:
 - i. A behavioral health medical practitioner as defined in R9-22-112, including a licensed psychologist, a licensed clinical social worker, a licensed professional counselor, a licensed marriage and family therapist; or
 - ii. An ADHS/DBHS-contracted provider.
 11. Transfer or discharge. The attending physician or the provider actually treating the non-FES member for the emergency behavioral health condition shall determine when the member is sufficiently stabilized for transfer or discharge and that decision shall be binding on the contractor and ADHS/DBHS or a subcontractor of ADHS/DBHS.
- B. Post-stabilization requirements for non-FES members.**
1. A contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that have been prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS.
 2. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain the member's stabilized condition within one hour of a request to the contractor, ADHS/DBHS, or a subcontractor for prior authorization of further post-stabilization services;
 3. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, as appropriate, is financially responsible for behavioral health post-stabilization services obtained within or outside the network that are not prior authorized by the contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, but are administered to maintain, improve, or resolve the member's stabilized condition if:
 - a. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS, does not respond to a request for prior authorization within one hour;
 - b. The contractor, ADHS/DBHS, or a subcontractor of ADHS/DBHS authorized to give the prior authorization cannot be contacted; or
 - c. The representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician cannot reach an agreement concerning the member's care and the contractor's, ADHS/DBHS' or the subcontractor's physician, is not available for consultation. The treating physician may continue with care of the member until ADHS/DBHS', the contractor's, or the subcontractor's physician is reached, or:
 - i. A contractor physician with privileges at the treating hospital assumes responsibility for the member's care;

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- ii. ADHS/DBHS', a contractor's, or a subcontractor's physician assumes responsibility for the member's care through transfer;
- iii. A representative of the contractor, ADHS/DBHS, or the subcontractor and the treating physician reach agreement concerning the member's care; or
- iv. The member is discharged.

R9-22-211. Transportation Services

A. Emergency ambulance services.

- 1. A member shall receive medically necessary emergency transportation in a ground or air ambulance:
 - a. To the nearest appropriate provider or medical facility capable of meeting the member's medical needs; and
 - b. If no other appropriate means of transportation is available.
- 2. The Administration or a member's contractor shall reimburse a ground or air ambulance transport that originates in response to a 911 call or other emergency response system:
 - a. If the member's medical condition justifies the medical necessity of the type of ambulance transportation received,
 - b. The transport is to the nearest appropriate provider or medical facility capable of meeting the member's medical needs, and
 - c. No prior authorization is required for reimbursement of these transports.
- 3. The member's medical condition at the time of transport determines whether the transport is medically necessary.
- 4. A ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system shall notify the member's contractor within 10 working days from the date of transport. Failure of the provider to ~~obtain prior authorization~~ provide notification is cause for denial.
- 5. Notification to the Administration of emergency transportation provided to a FFS member is not required, but the provider shall submit documentation with the claim which justifies the service.

B. The Administration or a contractor covers air ambulance services only if one or more of the criteria in subsection (B)(1), (2), or (3) is met. The criteria are:

- 1. The air ambulance transport is initiated at the request of:
 - a. An emergency response unit;
 - b. A law enforcement official;
 - c. A clinic or hospital medical staff member; or
 - d. A physician or practitioner; and
- 2. The point of pickup:
 - a. Is inaccessible by ground ambulance; or
 - b. Is a great distance from the nearest hospital or other provider with appropriate facilities to treat the member's condition; or
- 3. The medical condition of the member requires immediate:
 - a. Intervention from emergency ambulance personnel or providers with the appropriate facilities to treat the member's condition, or
 - b. Ground ambulance service will not suffice for the factors listed in subsection (B)(2).

C. Medically necessary nonemergency transportation is limited to the cost of transporting the member to an appropriate provider capable of meeting the member's medical needs.

- 1. As specified in contract, a contractor shall arrange or provide medically necessary nonemergency transportation services for a member who is unable to arrange transportation to a service site or location.
- 2. For a fee-for-service member, the Administration shall authorize medically necessary nonemergency transportation for a member who is unable to arrange transportation to a service site or location.

D. For the purposes of this subsection, an individual means a person who is not in the business of providing transportation services such as a family or household member, friend, or neighbor. The Administration or a contractor shall cover expenses for transportation in traveling to and returning from an approved and prior authorized health care service site provided by an individual if:

- 1. The transportation services are authorized by the Administration or the member's contractor or designee;
- 2. The individual is an AHCCCS registered provider; and
- 3. No other means of appropriate transportation is available.

E. The Administration or a contractor shall cover expenses for meals, lodging, and transportation for a member traveling to and returning from an approved ~~and prior authorized~~ health care service site outside of the member's service area or county of residence.

F. The Administration or a contractor shall cover the expense of meals, lodging, and transportation for:

- 1. A family member accompanying a member if:
 - a. The member is traveling to or returning from an approved and prior authorized health care service site outside of the member's service area or county of residence; and

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- b. The meals, lodging, and transportation services are authorized by the Administration or the member's contractor or designee.
- 2. An escort who is not a family member as follows:
 - a. If the member is travelling to or returning from an approved and prior authorized health care service site, including an inpatient facility, outside of the member's service area or county of residence; ~~and~~
 - b. If the escort services are authorized by the Administration or the member's contractor or designee; and
 - c. Wage paid to an escort as reimbursement shall not exceed the federal minimum wage.
- G. A provider shall obtain prior authorization from the Administration for transportation services provided for a member for the following:
 - 1. Medically necessary nonemergency transportation services not originated through a 911 call or other emergency response system when the distance traveled exceeds 100 miles (whether one way or round trip); and
 - 2. All meals, lodging, and services of an escort accompanying the member under this Section.
- H. A charitable organization routinely providing transportation service at no cost to an ambulatory or chairbound person shall not charge or seek reimbursement from the Administration or a contractor for the provision of the service to a member but may enter into a subcontract with a contractor for medically necessary transportation services provided to a member.

R9-22-215. Other Medical Professional Services

- A. The following medical professional services are covered services if a member receives these services in an inpatient, outpatient, or office setting as follows:
 - 1. Dialysis;
 - 2. The following family planning services if provided to delay or prevent pregnancy:
 - a. Medications;
 - b. Supplies;
 - c. Devices; and
 - d. Surgical procedures.
 - 3. Family planning services are limited to:
 - a. Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service;
 - b. Sterilization; and
 - c. Natural family planning education or referral;
 - 4. Midwifery services provided by a certified nurse practitioner in midwifery;
 - 5. Midwifery services for low-risk pregnancies and home deliveries provided by a licensed midwife;
 - 6. Respiratory therapy;
 - 7. Ambulatory and outpatient surgery facilities services;
 - 8. Home health services under A.R.S. § 36-2907(D);
 - 9. Private or special duty nursing services ~~when medically necessary and prior authorized~~;
 - 10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology within limitations in subsection (C);
 - 11. Total parenteral nutrition services, which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract;
 - 12. Inpatient chemotherapy; and
 - 13. Outpatient chemotherapy.
- B. Prior authorization from the Administration for a member is required for services listed in subsections (A)(4) through (11), except for:
 - 1. Voluntary sterilization.
 - 2. Dialysis shunt placement.
 - 3. Arteriovenous graft placement for dialysis.
 - 4. Angioplasties or thrombectomies of dialysis shunts.
 - 5. Angioplasties or thrombectomies of arteriovenous grafts for dialysis.
 - 6. Eye surgery for the treatment of diabetic retinopathy.
 - 7. Eye surgery for the treatment of glaucoma.
 - 8. Eye surgery for the treatment of macular degeneration.
 - 9. Home health visits following an acute hospitalization (limited up to five visits).
 - 10. Hysteroscopies, (up to two, one before and one after, when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization).
 - 11. Physical therapy subject to the limitation in subsection (C).
 - 12. Facility services related to wound debridement.

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13. Apnea management and training for premature babies up to the age of one.

14. Other services identified by the Administration through the Provider Participation Agreement.

C. The following services are excluded as covered services:

1. Occupational and speech therapies provided on an outpatient basis for a member age 21 or older;
2. Physical therapy provided only as a maintenance regimen;
3. Abortion counseling;
4. Services or items furnished solely for cosmetic purposes;
5. Services provided by a podiatrist; or
6. More than 15 outpatient physical therapy visits per contract year with the exception of the required Medicare coinsurance and deductible payment as described in 9 A.A.C. 29, Article 3.

R9-22-217. Services Included in the Federal Emergency Services Program

- A. Definition. For the purposes of this Section, an emergency medical or behavioral health condition for a FES member means a medical condition or a behavioral health condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
1. Placing the member's health in serious jeopardy,
 2. Serious impairment to bodily functions,
 3. Serious dysfunction of any bodily organ or part, or
 4. Serious physical harm to another person.
- B. Services. "Emergency services for a FES member" mean those medical or behavioral health services provided for the treatment of an emergency condition. Emergency services include outpatient dialysis services for an FES member with End Stage Renal Disease (ESRD) where a treating physician has certified that in his opinion the absence of receiving dialysis at least three times per week would reasonably be expected to result in:
1. Placing the patient's health in serious jeopardy, or
 2. Serious impairment of bodily function, or
 3. Serious dysfunction of a bodily organ or part.
- C. Covered services. Services are considered emergency services if all of the criteria specified in subsection (A) are satisfied at the time the services are rendered and timely notification as specified in subsection (E) is given. The Administration shall determine whether an emergency condition exists on a case-by-case basis.
- D. Prior authorization. A provider is not required to obtain prior authorization for emergency services for FES members. Prior authorization for outpatient dialysis services is met when the treating physician has completed and signed a monthly certification as described in subsection (B).
- ~~E. Notification. A provider shall notify the Administration no later than 72 hours after a FES member receiving emergency medical or behavioral health services presents to a hospital for inpatient services. The Administration may deny payment for failure to provide timely notice.~~

ARTICLE 7. STANDARDS FOR PAYMENTS

R9-22-703. Payments by the Administration

- A. General requirements. A provider shall enter into a provider agreement with the Administration that meets the requirements of A.R.S. § 36-2904 and 42 CFR 431.107(b) as of March 6, 1992, which is incorporated by reference and on file with the Administration, and available from the U.S. Government Printing Office, Mail Stop: IDCC, 732 N. Capitol Street, NW, Washington, DC, 20401. This incorporation by reference contains no future editions or amendments.
- B. Timely submission of claims.
1. Under A.R.S. § 36-2904, the Administration shall deem a paper or electronic claim to be submitted on the date that it is received by the Administration. The Administration shall do one or more of the following for each claim it receives:
 - a. Place a date stamp on the face of the claim,
 - b. Assign a system-generated claim reference number, or
 - c. Assign a system-generated date-specific number.
 2. Unless a shorter time period is specified in contract, the Administration shall not pay a claim for a covered service unless the claim is initially submitted within one of the following time limits, whichever is later:
 - a. Six months from the date of service or for an inpatient hospital claim, six months from the date of discharge; or
 - b. Six months from the date of eligibility posting.
 3. Unless a shorter time period is specified in contract, the Administration shall not pay a claim for a covered service unless the claim is submitted within one of the following time limits, whichever is later:
 - a. Twelve months from the date of service or for an inpatient hospital claim, ~~twelve~~ 12 months from the date of discharge; or
 - b. Twelve months from the date of eligibility posting.

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4. Unless a shorter time period is specified in contract, the Administration shall not pay a claim submitted by an IHS or tribal facility for a covered service unless the claim is initially submitted within 12 months from the date of service, date of discharge, or eligibility posting, whichever is later.
- C. Claims processing.
 1. The Administration shall notify the AHCCCS-registered provider with a remittance advice when a claim is processed for payment.
 2. The Administration shall reimburse a hospital for inpatient hospital admissions and outpatient hospital services rendered on or after March 1, 1993, as follows and in the manner and at the rate described in A.R.S. § 36-2903.01:
 - a. If the hospital bill is paid within 30 days from the date of receipt, the claim is paid at 99 percent of the rate.
 - b. If the hospital bill is paid between 30 and 60 days from the date of receipt, the claim is paid at 100 percent of the rate.
 - c. If the hospital bill is paid after 60 days from the date of receipt, the claim is paid at 100 percent of the rate plus a fee of one percent per month for each month or portion of a month following the 60th day of receipt of the bill until date of payment.
 3. A claim is paid on the date indicated on the disbursement check.
 4. A claim is denied as of the date of the remittance advice.
 5. The Administration shall process a hospital claim under this Article.
- D. Prior authorization.
 1. An AHCCCS-registered provider shall:
 - a. Obtain prior authorization from the Administration for non-emergency hospital admissions and covered services as specified in Articles 2 and 12 of this Chapter,
 - b. Notify the Administration of hospital admissions under Article 2 of this Chapter, and
 - c. Make records available for review by the Administration upon request.
 - ~~2. The Administration shall reduce payment of or deny claims, if an AHCCCS-registered provider fails to obtain prior authorization or notify the Administration under Article 2 of this Chapter and this Article.~~
 - ~~2. The providers failure to comply with subsection (D)(1) is a basis for denial of payment.~~
 3. If the Administration issues prior authorization for a specific level of care but subsequent medical review indicates that a different level of care was medically appropriate, the Administration shall adjust the claim to pay for the cost of the appropriate level of care.
- E. Review of claims and coverage for hospital supplies.
 1. The Administration may conduct prepayment and postpayment review of any claims, including but not limited to hospital claims.
 2. Personal care items supplied by a hospital, including but not limited to the following, are not covered services:
 - a. Patient care kit,
 - b. Toothbrush,
 - c. Toothpaste,
 - d. Petroleum jelly,
 - e. Deodorant,
 - f. Septi soap,
 - g. Razor or disposable razor,
 - h. Shaving cream,
 - i. Slippers,
 - j. Mouthwash,
 - k. Shampoo,
 - l. Powder,
 - m. Lotion,
 - n. Comb, and
 - o. Patient gown.
 3. The following hospital supplies and equipment, if medically necessary and used by the member, are covered services:
 - a. Arm board,
 - b. Diaper,
 - c. Underpad,
 - d. Special mattress and special bed,
 - e. Gloves,
 - f. Wrist restraint,
 - g. Limb holder,
 - h. Disposable item used instead of a durable item,
 - i. Universal precaution,
 - j. Stat charge, and

- k. Portable charge.
- 4. The Administration shall determine in a hospital claims review whether services rendered were:
 - a. Covered services as defined in R9-22-102;
 - b. Medically necessary;
 - c. Provided in the most appropriate, cost-effective, and least restrictive setting; and
 - d. For claims with dates of admission on and after March 1, 1993, substantiated by the minimum documentation specified in A.R.S. § 36-2903.01.
- 5. If the Administration adjudicates a claim, a person may file a claim dispute challenging the adjudication under 9 A.A.C. 34.
- F. Overpayment for AHCCCS services.
 - 1. An AHCCCS-registered provider shall notify the Administration when the provider discovers the Administration made an overpayment.
 - 2. The Administration shall recoup an overpayment from a future claim cycle if an AHCCCS-registered provider fails to return the overpaid amount to the Administration.
 - 3. The Administration shall document any recoupment of an overpayment on a remittance advice.
 - 4. An AHCCCS-registered provider may file a claim dispute under 9 A.A.C. 34 if the AHCCCS-registered provider disagrees with a recoupment action.

R9-22-712. Reimbursement: General

- A. Inpatient and outpatient discounts and penalties. If a claim is pending for additional documentation required under A.R.S. § 36-2903.01(H)(4), the period during which the claim is pending is not used in the calculation of the quick-pay discounts and slow-pay penalties under A.R.S. § 36-2903.01(H)(5).
- B. Inpatient and outpatient out-of-state hospital payments. In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse out-of-state hospitals for covered inpatient services by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio as determined in R9-22-712.01(6)(b). In the absence of a contract with an out-of-state hospital that specifies payment rates, AHCCCS shall reimburse an out-of-state hospital for covered outpatient services by applying the methodology described in R9-22-712.10 through R9-22-712.50. If the outpatient procedure is not assigned a fee schedule amount, the Administration shall pay the claim by multiplying the covered charges for the outpatient services by the state-wide outpatient cost-to-charge ratio.
- C. Access to records. Subcontracting and noncontracting providers of outpatient or inpatient hospital services shall allow the Administration access to medical records regarding eligible persons and shall in all other ways fully cooperate with the Administration or the Administration's designated representative in performance of the Administration's utilization control activities. The Administration shall deny a claim for failure to cooperate.
- D. Prior authorization. ~~The Administration shall deny a claim for failure to obtain prior authorization as required in R9-22-210. Failure to obtain prior authorization as required under R9-22-210 is a basis for denial of payment.~~
- E. Review of claims. Regardless of prior authorization or concurrent review activities, the Administration may subject all hospital claims, including outliers, to prepayment medical review or post-payment review, or both. The Administration shall conduct post-payment reviews consistent with A.R.S. § 36-2903.01 and may recoup erroneously paid claims. If prior authorization was given for a specific level of care but medical review of the claim indicates that a different level of care was appropriate, the Administration may adjust the claim to reflect the more appropriate level of care, effective on the date when the different level of care was medically appropriate.
- F. Claim receipt.
 - 1. The Administration's date of receipt of inpatient or outpatient hospital claims is the date the claim is received by the Administration as indicated by the date stamp on the claim and the system-generated claim reference number or system-generated date-specific number.
 - 2. Hospital claims are considered paid on the date indicated on disbursement checks.
 - 3. A denied claim is considered adjudicated on the date the claim is denied.
 - 4. Claims that are denied and are resubmitted are assigned new receipt dates.
 - 5. For a claim that is pending for additional supporting documentation specified in A.R.S. §§ 36-2903.01 or 36-2904, the Administration shall assign a new date of receipt upon receipt of the additional documentation.
 - 6. For a claim that is pending for documentation other than the minimum required documentation specified in either A.R.S. §§ 36-2903.01 or 36-2904, the Administration shall not assign a new date of receipt.
- G. Outpatient hospital reimbursement. The Administration shall pay for covered outpatient hospital services provided to eligible persons with dates of service from March 1, 1993 through June 30, 2005, at the AHCCCS outpatient hospital cost-to-charge ratio, multiplied by the amount of the covered charges.
 - 1. Computation of outpatient hospital reimbursement. The Administration shall compute the cost-to-charge ratio on a hospital-specific basis by determining the covered charges and costs associated with treating eligible persons in an outpatient setting at each hospital. Outpatient operating and capital costs are included in the computation but outpatient medical education costs that are included in the inpatient medical education component are excluded. To calcu-

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late the outpatient hospital cost-to-charge ratio annually for each hospital, the Administration shall use each hospital's Medicare Cost Reports and a database consisting of outpatient hospital claims paid and encounters processed by the Administration for each hospital, subjecting both to the data requirements specified in R9-22-712.01. The Administration shall use the following methodology to establish the outpatient hospital cost-to-charge ratios:

- a. Cost-to-charge ratios. The Administration shall calculate the costs of the claims and encounters for outpatient hospital services by multiplying the ancillary line item cost-to-charge ratios by the covered charges for corresponding revenue codes on the claims and encounters. Each hospital shall provide the Administration with information on how the revenue codes used by the hospital to categorize charges on claims and encounters correspond to the ancillary line items on the hospital's Medicare Cost Report. The Administration shall then compute the overall outpatient hospital cost-to-charge ratio for each hospital by taking the average of the ancillary line items cost-to-charge ratios for each revenue code weighted by the covered charges.
- b. Cost-to-charge limit. To comply with 42 CFR 447.325, the Administration may limit cost-to-charge ratios to 1.00 for each ancillary line item from the Medicare Cost Report. The Administration shall remove ancillary line items that are non-covered or not applicable to outpatient hospital services from the Medicare Cost Report data for purposes of computing the overall outpatient hospital cost-to-charge ratio.
2. New hospitals. The Administration shall reimburse new hospitals at the weighted statewide average outpatient hospital cost-to-charge ratio multiplied by covered charges. The Administration shall continue to use the statewide average outpatient hospital cost-to-charge ratio for a new hospital until the Administration rebases the outpatient hospital cost-to-charge ratios and the new hospital has a Medicare Cost Report for the fiscal year being used in the rebasing.
3. Specialty outpatient services. The Administration may negotiate, at any time, reimbursement rates for outpatient hospital services in a specialty facility.
4. Reimbursement requirements. To receive payment from the Administration, a hospital shall submit claims that are legible, accurate, error free, and have a covered charge greater than 0. The Administration shall not reimburse hospitals for emergency room treatment, observation hours or days, or other outpatient hospital services performed on an outpatient basis, if the eligible person is admitted as an inpatient to the same hospital directly from the emergency room, observation area, or other outpatient department. Services provided in the emergency room, observation area, and other outpatient hospital services provided before the hospital admission are included in the tiered per diem payment.
5. Rebasing. The Administration shall rebase the outpatient hospital cost-to-charge ratios at least every four years but no more than once a year using updated Medicare Cost Reports and claim and encounter data.
6. If a hospital files an increase in its charge master for an existing outpatient service provided on or after July 1, 2004, and on or before June 30, 2005, which represents an aggregate increase in charges of more than 4.7 percent, the Administration shall adjust the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through ~~(G)(5)~~ (5) by applying the following formula:

$$CCR * [1.047 / (1 + \% \text{ increase})]$$

Where "CCR" means the hospital-specific cost-to-charge ratio as calculated under subsection (G)(1) through ~~(G)(5)~~ (5) and "% increase" means the aggregate percentage increase in charges for outpatient services shown on the hospital charge master.

"Charge master" means the schedule of rates and charges as described under A.R.S. § 36-436 and the rules that relate to those rates and charges that are filed with the Director of the Arizona Department of Health Services.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM CHILDREN'S HEALTH INSURANCE PROGRAM

Editor's Note: The following Notice of Proposed Rulemaking was reviewed per Laws 2010, Ch. 287, § 18. (See the text of § 18 on page 515.) The Governor's Office authorized the notice to proceed through the rulemaking process on February 28, 2011.

[R11-29]

PREAMBLE

1. Sections Affected

R9-31-201
R9-31-204

Rulemaking Action

Amend
Amend

Notices of Proposed Rulemaking

R9-31-215	Amend
R9-31-1601	Amend
R9-31-1602	Repeal
R9-31-1603	Repeal
R9-31-1604	Repeal
R9-31-1605	Repeal
R9-31-1606	Repeal
R9-31-1607	Repeal
R9-31-1608	Repeal
R9-31-1609	Repeal
R9-31-1610	Repeal
R9-31-1611	Repeal
R9-31-1612	Repeal
R9-31-1613	Repeal
R9-31-1614	Repeal
R9-31-1615	Repeal
R9-31-1622	Repeal
R9-31-1625	Repeal

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. §§ 36-2903.01, 36-2907

Implementing statute: A.R.S. § 36-2907

3. A list of all previous notices appearing in the *Register* addressing the proposed rule:

Notice of Rulemaking Docket Opening: 17 A.A.R. 514, April 8, 2011 (*in this issue*)

4. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Mariaelena Ugarte
Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson St., Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4693
Fax: (602) 253-9115
E-mail: AHCCCSRules@azahcccs.gov

5. An explanation of the rule, including the agency's reasons for initiating the rule:

The proposed rules will eliminate the requirement for obtaining PA for services such as, but not limited to: dialysis shunt placement, apnea management and training for premature babies up to one year of life, certain eye surgeries, and hospitalizations for labor and delivery not exceeding specific time parameters. In addition, technical changes and striking of redundant rules will be made.

6. A reference to any study relevant to the rules that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

A study was not relied upon for purposes of this rulemaking.

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

8. The preliminary summary of the economic, small business, and consumer impact:

The AHCCCS Administration believes that subjecting the identified services to PA adds administrative costs and time-consuming processes to Agency operations, further straining limited program resources without accompanying benefits. This amendment also reduces the administrative burden on health care providers and facilitates members' access to appropriate care.

Currently 95 percent of the cases are approved. The Administration believes that removal of this requirement will save the provider time and money. Each PA takes 10 minutes and each biller is making approximately \$15 an hour, possibly saving providers \$14,000 in a year. The Administration will also save time and money for the cost of the PA nurse's time, estimated to be \$28,000 a year.

9. The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:

Notices of Proposed Rulemaking

Name: Mariaelena Ugarte
Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson St., Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4693
Fax: (602) 253-9115
E-mail: AHCCCSRules@azahcccs.gov

Proposed rule language will be available on the AHCCCS web site www.azahcccs.gov the week of March 21, 2011. Please send written comments to the above address by 5:00 p.m., May 10, 2011. E-mail comments will also be accepted during this time-frame.

10. The time, place, and nature of the proceedings for the making, amendment, or repeal of the rule, or if no proceeding is scheduled, where, when, and how persons may request an oral proceeding on the proposed rule:

Date: May 10, 2011
Time: 2:00 p.m.
Location: AHCCCS
701 E. Jefferson St.
Phoenix, AZ 85034
Nature: Public Hearing

Date: May 10, 2011
Time: 2:00 p.m.
Location: ALTCS: Arizona Long-term Care System
1010 N. Finance Center Drive, Suite 201
Tucson, AZ 85710
Nature: Public Hearing

Date: May 10, 2011
Time: 2:00 p.m.
Location: DAHL /Office of Special Investigations
2721 N. 4th St., Suite 23
Flagstaff, AZ 86004
Nature: Public Hearing

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

12. Incorporations by reference and their location in the rules:

None

13. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

**CHAPTER 31. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CHILDREN'S HEALTH INSURANCE PROGRAM**

ARTICLE 2. SCOPE OF SERVICES

Section
R9-31-201. General Requirements
R9-31-204. Inpatient General Hospital Services
R9-31-215. Other Medical Professional Services

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

Section
R9-31-1601. General Requirements
R9-31-1602. ~~General Requirements for Scope of Services~~ Repealed

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- R9-31-1603. Inpatient General Hospital Services Repealed
- R9-31-1604. Physician and Primary Care Physician and Practitioner Services Repealed
- R9-31-1605. Organ and Tissue Transplantation Services Repealed
- R9-31-1606. Dental Services Repealed
- R9-31-1607. Laboratory, Radiology, and Medical Imaging Services Repealed
- R9-31-1608. Pharmaceutical Services Repealed
- R9-31-1609. Emergency Services Repealed
- R9-31-1610. Transportation Services Repealed
- R9-31-1611. Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies Repealed
- R9-31-1612. Health Risk Assessment and Screening Services Repealed
- R9-31-1613. Other Medical Professional Services Repealed
- R9-31-1614. NF, Alternative HCBS Setting, or HCBS Repealed
- R9-31-1615. Eligibility and Enrollment Repealed
- R9-31-1622. The Administration's Liability to Hospitals for the Provision of Emergency and Subsequent Care Repealed
- R9-31-1625. Behavioral Health Services Repealed

ARTICLE 2. SCOPE OF SERVICES

R9-31-201. General Requirements

- A. The Administration shall administer the Children's Health Insurance Program under A.R.S. § 36-2982.
- B. Scope of services for Native American fee-for-service members is under Article 16 of this Chapter.
- C. A contractor or RBHA shall provide behavioral health services under ~~Article~~ Articles 12 and Article 16.
- D. In addition to other requirements and limitations specified in this Chapter, the following general requirements apply:
 - 1. Only medically necessary, cost effective, and federally- reimbursable and state-reimbursable services are covered services.
 - 2. The Administration or a contractor may waive the covered services referral requirements of this Article.
 - 3. Except as authorized by a contractor, a primary care provider, practitioner, or dentist shall provide or direct the member's covered services. Delegation of the provision of care to a practitioner does not diminish the role or responsibility of the primary care provider.
 - 4. A contractor shall offer a female member direct access to preventive and routine services from gynecology providers within the contractor's network without a referral from a primary care provider.
 - 5. ~~A member may receive behavioral health evaluation services without a referral from a primary care provider. A member may receive behavioral health treatment services only under referral from the primary care provider, or upon authorization by the contractor or the contractor's designee. A member may receive behavioral health services as specified in 9 A.A.C. 22, Articles 2 and 12.~~
 - 6. A member may receive treatment that is considered the standard of care, or that is approved by the AHCCCS Chief Medical Officer after appropriate input from providers who are considered experts in the field by the professional medical community.
 - 7. An AHCCCS registered provider shall provide covered services within the provider's scope of practice.
 - 8. In addition to the specific exclusions and limitations otherwise specified under this Article, the following are not covered:
 - a. A service that is determined by the AHCCCS Chief Medical Officer to be experimental or provided primarily for the purpose of research;
 - b. Services or items furnished gratuitously; and
 - c. Personal care items, except as specified in R9-31-212.
 - 9. Medical or behavioral health services are not covered if provided to:
 - a. An inmate of a public institution;
 - b. A person who is a resident of an institution for the treatment of tuberculosis; or
 - c. A person who is in an IMD at the time of application, unless provided under Article 12 of this Chapter.
- ~~E. The Administration or a contractor may deny payment of non-emergency services if prior authorization is not obtained under this Article and Article 7 of this Chapter. The Administration or a contractor shall not reimburse services that require prior authorization unless the provider documents the diagnosis and treatment.~~
- E. Failure to obtain prior authorization as specified in this Article and Article 7 of this Chapter is a basis for denial of payment for non-emergency services. The Administration or a contractor shall not provide prior authorization for services unless the provider submits documentation of the medical necessity of the treatment along with the prior authorization request.
- F. Prior authorization is not required for services necessary to evaluate and stabilize an emergency medical condition.
- G. Under A.R.S. § 36-2989, a member shall receive covered services outside of the GSA only if one of the following applies:
 - 1. A member is referred by a primary care provider for medical specialty care out of the contractor's area. If the

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- member is referred outside of the GSA to receive an authorized medically necessary service, a contractor shall also provide all other medically necessary covered services for the member;
2. There is a net savings in service delivery costs as a result of going outside the GSA that does not require undue travel time or hardship for a member or the member's family; or
 3. The contractor authorizes placement in a nursing facility located outside of the GSA.
- H. If a member is traveling or temporarily residing outside of the GSA, covered services are restricted to emergency care services, unless otherwise authorized by the contractor.
- I. A contractor shall provide at a minimum, directly or through subcontracts, the covered services specified in this Chapter and in contract.
- J. The restrictions, limitations, and exclusions in this Article do not apply to a contractor if the contractor elects to provide noncovered services.
1. The Administration shall not consider the costs of providing a noncovered service to a member in the development or negotiation of a capitation rate.
 2. A contractor shall pay for noncovered services from administrative revenue or other contractor funds that are unrelated to the provision of services under this Chapter.

R9-31-204. Inpatient General Hospital Services

A contractor, fee-for-service provider, or noncontracting provider shall render inpatient general hospital services including:

1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
 - a. Maternity care, including labor, delivery, recovery room, birthing center, and newborn nursery;
 - b. Neonatal intensive care unit (NICU);
 - c. Intensive care unit (ICU);
 - d. Surgery, including surgery room and recovery room;
 - e. Nursery and related services;
 - f. Routine care; and
 - g. Emergency behavioral health services under ~~9 A.A.C. 31~~, Article 12.
2. Ancillary services as specified by the Director and included in contract:
 - a. Laboratory services;
 - b. Radiological and medical imaging services;
 - c. Anesthesiology services;
 - d. Rehabilitation services;
 - e. Pharmaceutical services and prescription drugs;
 - f. Respiratory therapy;
 - g. Blood and blood derivatives; and
 - h. Central supply items, appliances, and equipment not ordinarily furnished to all patients which are customarily reimbursed as ancillary services.
3. Providers are not required to obtain prior authorization from the Administration for the following inpatient hospital services:
 - a. Dialysis shunt placement.
 - b. Arteriovenous graft placement for dialysis.
 - c. Angioplasties or thrombectomies of dialysis shunts.
 - d. Angioplasties or thrombectomies of arteriovenous graft for dialysis.
 - e. Hospitalization for vaginal delivery that does not exceed 48 hours.
 - f. Hospitalization for cesarean section delivery that does not exceed 96 hours, and
 - h. Other services identified by the Administration through the Provider Participation Agreement.

R9-31-215. Other Medical Professional Services

- A. The following medical professional services are covered services if a member receives these services in an inpatient, outpatient, or office setting as follows:
1. Dialysis;
 2. The following family planning services if provided to delay or prevent pregnancy:
 - a. Medications,
 - b. Supplies,
 - c. Devices, and
 - d. Surgical procedures.
 3. Family planning services are limited to:
 - a. Contraceptive counseling, medication, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service; and

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- b. Natural family planning education or referral;
4. Midwifery services provided by a nurse practitioner certified in midwifery;
5. Podiatry services if ordered by a member's primary care provider as specified in A.R.S. § 36-2989;
6. Respiratory therapy;
7. Ambulatory and outpatient surgery facilities services;
8. Home health services in A.R.S. § 36-2989;
9. Private or special duty nursing services ~~if medically necessary and prior authorized;~~
10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology provided under this Article;
11. Total parenteral nutrition services, (which are the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract);
12. Inpatient chemotherapy;
13. Outpatient chemotherapy; and
14. Hospice care under A.A.C. R9-22-213

B. Prior authorization from the Administration for a member is required for services listed in subsections (A)(4) through (11) and (A)(14), except for:

1. Dialysis shunt placement;
2. Arteriovenous graft placement for dialysis;
3. Angioplasties or thrombectomies of dialysis shunts;
4. Angioplasties or thrombectomies of arteriovenous grafts for dialysis;
5. Eye surgery for the treatment of diabetic retinopathy;
6. Eye surgery for the treatment of glaucoma;
7. Eye surgery for the treatment of macular degeneration;
8. Home health visits following an acute hospitalization (limited up to five visits);
9. Hysteroscopies, (up to two, one before and one after, when associated with a family planning diagnosis code and done within 90 days of hysteroscopic sterilization);
10. Physical therapy subject to the limitation in subsection (C);
11. Facility services related to wound debridement;
12. Apnea management and training for premature babies up to the age of one; and
13. Other services identified by the Administration through the Provider Participation Agreement.

ARTICLE 16. SERVICES FOR NATIVE AMERICANS

R9-31-1601. General Requirements

- A.** A Native American who is a member may receive:
1. Covered acute care services specified in this Chapter from:
 - a. Indian Health Service (IHS) under A.R.S. § 36-2982 if IHS has a signed agreement with the Administration,
 - b. A Tribal Facility under A.R.S. § 36-2982, ~~or~~
 - c. A contractor under A.R.S. § 36-2901-, or
 - d. An AHCCCS registered provider.
 2. Covered behavioral health care services as specified in this Chapter from:
 - a. IHS under A.R.S. § 36-2982 if IHS has a signed agreement with the Administration,
 - b. A Tribal Facility under A.R.S. § 36-2982, or
 - c. A RBHA or TRBHA.
- B.** IHS, a Tribal facility, or a referred provider shall meet the requirements in this Chapter and 9 A.A.C. Chapter 22, Articles 2 and Article 7 to receive reimbursement for AHCCCS-covered services. The following ~~sections~~ Sections of 9 A.A.C. Chapter 22, Article Articles 2 and 7 are applicable to reimbursement for AHCCCS-covered services provided to a Native American member under the KidsCare program, except that the term "IHS," "Tribal facility," or "referred provider" is substituted for "provider":
1. Scope of the Administration's Liability, A.A.C. R9-22-701.10;
 2. Charges to Members, A.A.C. R9-22-702;
 3. Prior authorization, A.A.C. R9-22-703(D);
 4. Claims Review, A.A.C. R9-22-703(E);
 5. Payments by the Administration, A.A.C. R9-22-703;
 6. Payments for Services Provided to Eligible Native Americans, A.A.C. R9-22-708;
 7. Payments to Providers, A.A.C. R9-22-714; and
 8. Specialty Contracts, A.A.C. R9-22-712(G)(3), R9-22-712.01(10).

R9-31-1602. General Requirements for Scope of Services ~~Repealed~~

~~**A.** In addition to the requirements and the limitations specified in this Chapter, the following general requirements apply:~~

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1. Under A.R.S. § 36-2989, covered services provided to a member shall be medically necessary and provided by, or under the direction of, the IHS, a Tribal Facility, a provider, or a dentist. Specialist services are provided under referral from the IHS or a Tribal Facility provider.
 2. If IHS cannot provide a covered service due to in the appropriation of funds by Congress, the obligation to allocate IHS program resources nationwide, or a fundamental shift in the manner of providing health services to Native Americans on a national basis then a member shall be referred to a non IHS provider or a non IHS facility for the service.
- B.** As specified in A.R.S. § 36-2989, covered services rendered to a member are provided within the service area of the IHS or a Tribal Facility except when:
1. An IHS or a Tribal Facility refers a member out of the area for medical specialty care or behavioral health services;
 2. A covered service that is medically necessary for a member is not available within the service area; or
 3. A member is placed in an NF located out of the service area.
- C.** If a member requests the provision of service that is not covered or not authorized by the IHS or Tribal Facility, an AHC-CCS registered provider may provide the service under the following conditions:
1. IHS or a Tribal Facility shall prepare and provide the member with a document that lists the requested services and the estimated cost of each service; and
 2. The member signs a document prior to the provision of services indicating that the member understands the services and accepts the responsibility for payment.
- D.** Nonecovered services provided to a member by the IHS, a Tribal Facility or under referral may be paid by the IHS or a Tribal Facility, but not with Title XXI funds.

R9-31-1603. Inpatient General Hospital Services Repealed

- A.** A fee for service provider or non-contracting provider shall provide the following inpatient general hospital services including:
1. Hospital accommodations and appropriate staffing, supplies, equipment, and services for:
 - a. Maternity care, including labor, delivery, and recovery room, birthing center, and newborn nursery;
 - b. Neonatal intensive care (NICU);
 - c. Intensive care (ICU);
 - d. Surgery, including surgery room and recovery room;
 - e. Nursery;
 - f. Routine care; and
 - g. Emergency behavioral services under 9 A.A.C. 31, Article 12;
 2. The following ancillary services including:
 - a. Laboratory services;
 - b. Radiological and medical imaging services;
 - c. Anesthesiology services;
 - d. Rehabilitation services;
 - e. Pharmaceutical services and prescription drugs;
 - f. Respiratory therapy;
 - g. Blood and blood derivatives; and
 - h. Central supply items, appliances, and equipment that are not ordinarily furnished to all patients which are customarily reimbursed as ancillary services.
- B.** The following limitations apply to inpatient general hospital services that are provided by a FFS provider:
1. A provider shall obtain prior authorization from the Administration for the following inpatient hospital services:
 - a. Nonemergency and elective admission, including psychiatric hospitalization;
 - b. Elective surgery, excluding a voluntary sterilization procedure. A voluntary sterilization procedure does not require prior authorization; and
 - c. A service or items provided to reconstruct or improve personal appearance after an illness or injury.
 2. The Administration may perform concurrent review for hospitalizations to determine whether there is medical necessity for the hospitalization.
 - a. A provider shall notify the Administration no later than the fourth day of hospitalization after an emergency admission or no later than the second day after an intensive care unit admission so that the Administration may initiate concurrent review of the hospitalization.
 - b. Failure of the provider to obtain prior authorization is cause for denial of a claim.

R9-31-1604. Physician and Primary Care Physician and Practitioner Services Repealed

- A.** Primary care services shall be furnished by a physician or a primary care practitioner. Primary care services may be provided in an inpatient or outpatient setting and shall include:
1. Periodic health examinations and assessments;
 2. Evaluations and diagnostic workups;

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3. Prescriptions for medications and medically necessary supplies and equipment;
 4. Referrals to a specialist or other health care professional when medically necessary as specified in A.R.S. § 36-2989;
 5. Patient education;
 6. Home visits when determined medically necessary;
 7. Covered immunizations; and
 8. Covered preventive health services.
- B.** As specified in A.R.S. § 36-2989, a second opinion procedure may be required to determine coverage for surgeries for a member referred out of the IHS or a Tribal Facility. Under this procedure, documentation must be provided by at least two physicians as to the need for the proposed surgery.
- C.** The following limitations and exclusions apply to physician and practitioner services and primary care provider services for a member referred out of the IHS or a Tribal Facility:
1. Specialty care and other services provided to a member upon referral from a primary care provider shall be limited to the services or conditions for which the referral is made, or for which authorization is given;
 2. If a physical examination is performed with the primary intent to accomplish one or more of the objectives listed in subsection (A), it may be covered by the IHS or a Tribal Facility except if there is an additional or alternative objective to satisfy the demands of an outside public or private agency. Alternative objectives may include physical examinations and resulting documentation for:
 - a. Qualification for insurance;
 - b. Pre-employment physical evaluation;
 - c. Qualification for sports or physical exercise activities;
 - d. Pilot's examination (FAA);
 - e. Disability certification for establishing any kind of periodic payments;
 - f. Evaluation for establishing third-party liabilities; or
 - g. Physical ability to perform functions that have no relationship to primary objectives listed in subsection (A).
 3. The following services shall be excluded from Title XXI coverage:
 - a. Infertility services, reversal of surgically induced infertility (sterilization), and sex change operations;
 - b. Services or items furnished solely for cosmetic purposes;
 - c. Hysterectomies, unless determined to be medically necessary;
 - d. Abortion counseling or abortion except according to federal law;
 - e. Chiropractic services; and
 - f. Licensed midwife service for prenatal care and home births.

R9-31-1605. Organ and Tissue Transplantation Services Repealed

- A.** The following organ and tissue transplantation services are covered for a member as specified in A.R.S. § 36-2989 if prior authorized by the Administration:
1. Kidney transplantation;
 2. Simultaneous Kidney/Pancreas transplant;
 3. Cornea transplantation;
 4. Heart transplantation;
 5. Liver transplantation;
 6. Autologous and allogenic bone marrow transplantation;
 7. Lung transplantation;
 8. Heart-lung transplantation; and
 9. Other organ transplantation if the transplantation is required by federal law and if other statutory criteria are met.
- B.** Immunosuppressant medications, chemotherapy, and other related services provided in an IHS, a Tribal Facility, or by a referral provider do not need to be prior authorized.

R9-31-1606. Dental Services Repealed

Medically necessary dental services shall be provided for children under age 19 as specified in A.R.S. § 36-2989.

R9-31-1607. Laboratory, Radiology, and Medical Imaging Services Repealed

As specified in A.R.S. § 36-2989, laboratory, radiology, and medical imaging services may be covered services if:

1. Prescribed for a member by an IHS, a Tribal Facility care provider or a dentist, or if prescribed by a physician or a practitioner upon referral from the IHS, a Tribal Facility provider or a dentist;
2. Provided in a hospital, a clinic, a physician office, or other health care facility by IHS or a Tribal Facility provider; or
3. Provided by an IHS or a Tribal Facility provider that meets all applicable state and federal license and certification requirements and provides only services that are within the scope of practice stated in a provider's license or certification.

R9-31-1608. Pharmaceutical Services Repealed

- ~~A.~~ Pharmaceutical services may be provided by the IHS, a Tribal Facility, or upon referral from an IHS or a Tribal Facility provider.
- ~~B.~~ As specified in A.R.S. § 36-2989, pharmaceutical services are covered if prescribed for a member by the IHS, a Tribal Facility provider or a dentist, or if prescribed by a specialist upon referral from the IHS or a Tribal Facility provider.
- ~~C.~~ The following limitations apply to pharmaceutical services:
 - 1. A medication personally dispensed by a physician or a dentist, or a practitioner within the individual's scope of practice, is not covered, except in geographically remote areas where there is no participating pharmacy or if accessible pharmacies are closed.
 - 2. A prescription or refill in excess of 100 unit doses is not covered. A prescription or refill in excess of a 30-day supply is not covered unless specified in subsection (C)(3).
 - 3. A prescription or refill in excess of a 30-day supply is covered if:
 - a. The medication is prescribed for a chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit doses, whichever is greater.
 - b. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed a 100-day supply or 100-unit doses, whichever is greater.
 - c. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.
 - 4. An over-the-counter medication in place of a covered prescription medication is covered only if the over-the-counter medication is appropriate, equally effective, safe, and is less costly than the covered prescription medication.
- ~~D.~~ The IHS or a Tribal Facility shall monitor and ensure sufficient services to prevent any gap in the pharmaceutical regimen of a member who requires a continuing or complex regimen of pharmaceutical treatment to restore, improve, or maintain physical well-being.

R9-31-1609. Emergency Services Repealed

Emergency medical services provided by the IHS, a Tribal Facility, or a referral provider outside the service area shall be provided based on the prudent layperson standard to a member by the IHS or a Tribal Facility provider registered with AHCCCS to provide services as specified in A.R.S. § 36-2989.

R9-31-1610. Transportation Services Repealed

The Administration shall provide transportation services under A.A.C. R9-22-211.

R9-31-1611. Durable Medical Equipment, Orthotic and Prosthetic Devices, and Medical Supplies Repealed

Durable medical equipment, orthotic and prosthetic devices, and medical supplies, including incontinence briefs, are covered services if provided in compliance with the requirements of this Chapter and A.A.C. R9-22-212. For purposes of this Section, where the phrase "AHCCCS services" is used in R9-22-212, it is replaced with the phrase "Title XXI services." Where the term "provider" or "contractor" is used, it is replaced with the phrase "IHS or Tribal facility."

R9-31-1612. Health Risk Assessment and Screening Services Repealed

- ~~A.~~ As specified in A.R.S. § 36-2989, the following services shall be covered for a member less than 19 years of age:
 - 1. Screening services, including:
 - a. Comprehensive health, behavioral health, and developmental histories;
 - b. Comprehensive unclothed physical examination;
 - c. Appropriate immunizations according to age and health history;
 - d. Health education, including anticipatory guidance; and
 - e. Laboratory tests.
 - 2. Vision services including:
 - a. Diagnosis and treatment for defects in vision.
 - b. Eye examinations for the provision of prescriptive lenses, and
 - c. Provision of prescriptive lenses.
 - 3. Hearing services, including:
 - a. Diagnosis and treatment for defects in hearing;
 - b. Testing to determine hearing impairment, and
 - c. Provision of hearing aids.
- ~~B.~~ Providers of services shall meet the following standards:
 - 1. Provide services by or under the direction of a member's IHS or a Tribal Facility provider or a dentist;
 - 2. Perform tests and examinations under 42 CFR 441, Subpart B, January 29, 1985, which is incorporated by reference and on file with the Office of the Secretary of State and the Administration. This incorporation by reference contains no future editions or amendments;
 - 3. Refer a member as necessary for dental diagnosis and treatment, and necessary specialty care; and
 - 4. Refer a member as necessary for behavioral health evaluation and treatment services as specified in this Article.
- ~~C.~~ The IHS or a Tribal Facility shall meet additional conditions for a member as stated in the Intergovernmental Agreement

between the Administration and IHS.

- ~~D.~~ The IHS or a Tribal Facility provider shall refer a member with special health care needs under A.A.C. R9-7-301 to CRS.

R9-31-1613. Other Medical Professional Services Repealed

- ~~A.~~ The following medical professional services are covered services if a member receives these services in an inpatient, an outpatient, or an office setting as follows:
- ~~1. Dialysis;~~
 - ~~2. The following family planning services if provided to delay or prevent pregnancy:~~
 - ~~a. Medications;~~
 - ~~b. Supplies;~~
 - ~~c. Devices; and~~
 - ~~d. Surgical procedures.~~
 - ~~3. Family planning services are limited to:~~
 - ~~a. Contraceptive counseling, medication, supplies, and associated medical and laboratory examinations, including HIV blood screening as part of a package of sexually transmitted disease tests provided with a family planning service; and~~
 - ~~b. Natural family planning education or referral;~~
 - ~~4. Midwife services provided by a certified nurse practitioner;~~
 - ~~5. Podiatry services if ordered by an IHS or a Tribal Facility provider;~~
 - ~~6. Respiratory therapy;~~
 - ~~7. Ambulatory and outpatient surgery facilities services;~~
 - ~~8. Home health services;~~
 - ~~9. Private or special duty nursing services if medically necessary and prior authorized;~~
 - ~~10. Rehabilitation services including physical therapy, occupational therapy, speech therapy, and audiology provided under this Article;~~
 - ~~11. Total parenteral nutrition services which is the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract;~~
 - ~~12. Hospice care under R9-22-213;~~
 - ~~13. Inpatient chemotherapy; and~~
 - ~~14. Outpatient chemotherapy.~~
- ~~B.~~ The Administration shall prior authorize services in subsections (A)(4) through (12) for a member referred out of the IHS or a Tribal Facility service area.

R9-31-1614. NF, Alternative HCBS Setting, or HCBS Repealed

- ~~A.~~ Services provided in a NF, including room and board, an alternative HCBS setting, or a HCBS as defined under A.R.S. § 36-2939 are covered for a maximum of 90 days per contract year if the member's medical condition would otherwise require hospitalization.
- ~~B.~~ Except as otherwise provided in 9 A.A.C. 28, the following services are not itemized for separate billing if provided in a NF, alternative HCBS setting, or HCBS:
- ~~1. Nursing services, including:~~
 - ~~a. Administration of medication;~~
 - ~~b. Tube feeding;~~
 - ~~c. Personal care services, including but not limited to assistance with bathing and grooming;~~
 - ~~d. Routine testing of vital signs; and~~
 - ~~e. Maintenance of catheter.~~
 - ~~2. Basic patient care equipment and sickroom supplies, including:~~
 - ~~a. First aid supplies such as bandages, tape, ointment, peroxide, alcohol, and over the counter remedies;~~
 - ~~b. Bathing and grooming supplies;~~
 - ~~c. Identification device;~~
 - ~~d. Skin lotion;~~
 - ~~e. Medication cup;~~
 - ~~f. Alcohol wipes, cotton balls, and cotton rolls;~~
 - ~~g. Rubber gloves (non-sterile);~~
 - ~~h. Laxatives;~~
 - ~~i. Bed and accessories;~~
 - ~~j. Thermometer;~~
 - ~~k. Ice bag;~~
 - ~~l. Rubber sheeting;~~
 - ~~m. Passive restraints;~~

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- n- Glycerin swabs;
 - o- Facial tissue;
 - p- Enemas;
 - q- Heating pad; and
 - r- Diapers.
- 3- Dietary services including preparing and administering special diets or adaptive tools for eating;
 - 4- Any service that is included in a NF's room and board charge or a service that is required of the NF to meet a federal mandate, state licensure standard, or county certification requirement;
 - 5- Physical therapy; and
 - 6- Assistive device or non-customized DME.
- ~~C- The Administration shall prior authorize each NF admission outside the IHS or a Tribal Facility's service area.~~

R9-31-1615. Eligibility and Enrollment Repealed

The eligibility and enrollment provisions specified in 9 A.A.C. 31, Article 3 apply to a Native American who elects to receive services through the IHS or a Tribal Facility.

R9-31-1622. The Administration's Liability to Hospitals for the Provision of Emergency and Subsequent Care Repealed

- ~~A- Expenses for an emergency or acute medical health condition of a member are reimbursed only until the member's condition is stabilized and the member is transferable, or until the member is discharged following stabilization subject to the requirements of this Chapter and A.R.S. § 36-2989. This Section only applies to those noncontracting hospitals outside the IHS or Tribal Facility network.~~
- ~~B- Subject to subsection (A), if a member cannot be transferred following stabilization to the IHS or a Tribal Facility, the Administration shall pay for all appropriately documented, prior authorized, and medically necessary treatment provided to a member before the discharge date or transfer under R9-31-705.~~
- ~~C- If a member refuses transfer from a noncontracting provider or a noncontracting hospital to the IHS or a Tribal Facility, the Administration is not liable for any costs incurred after the date of refusal if:

 - 1- After consultation with a member's IHS or a Tribal Facility, a member continues to refuse the transfer; and
 - 2- A member is provided and signs a written statement, before the date the member is liable for payment informing a member of the medical and financial consequences of refusing to transfer. If a member refuses to sign a written statement, a statement signed by two witnesses indicating that the member was informed may be substituted.~~

R9-31-1625. Behavioral Health Services Repealed

- ~~A- The IHS, a TRBHA, a RBHA or a Tribal Facility may provide any or all of the behavioral health services specified in 9 A.A.C. 31, Article 12, subject to the limitations and specifications stated in 9 A.A.C. 31, Article 12, to a Native American who is a member.~~
- ~~B- The IHS, a Tribal Facility, a contractor, a TRBHA or a RBHA shall cooperate as specified in contract, IGA, or this Chapter when the transition from one entity to another becomes necessary.~~
- ~~C- The IHS and a Tribal Facility shall be considered a provider for the provision of behavioral health services and shall be subject to the requirements of:

 - 1- A TRBHA if one is operating in a service area; or
 - 2- A RBHA in a service area that does not have a TRBHA or a contractor for a Native American member with respect to prior authorization and service authorizations.~~
- ~~D- If either the IHS or a Tribal Facility cannot provide a nonemergency inpatient or an outpatient behavioral health service, the IHS or a Tribal Facility shall refer the member to a RBHA or a TRBHA.~~
- ~~E- If a member is enrolled with a contractor and is not enrolled with a TRBHA or a RBHA, the contractor is responsible for the provision of emergency behavioral health services for up to three days per admission, not to exceed 12 days per contract year, and shall refer a member to a TRBHA or a RBHA for continued service authorization and any needed additional services.~~
- ~~F- The provider shall obtain prior authorization for all inpatient hospitalizations and partial care services as authorized in R9-31-1202 and R9-31-1203.~~
- ~~G- A provider shall comply with the requirements specified in subsections (B) and (C). If a provider fails to comply, payment is denied, or if paid, is recouped by the Administration.~~
- ~~H- A behavioral health service provided by the IHS or a Tribal Facility shall be reimbursed as specified in R9-31-1616.~~